RURAL HEALTH CARE

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OF THE

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RURAL HEALTH CARE

MONDAY, JUNE 29, 1981

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Billings, Mont.

The subcommittee met, pursuant to notice, at 9 a.m., in the Billings, Sheraton Hotel, Billings, Mont., Hon. Max Baucus (chairman of the subcommittee) presiding.

Present: Senators Baucus and Durenberger.

[The committee press release announcing these hearings follows:]

Senator BAUCUS. The hearing will come to order.

I would like to first thank Senator Dave Durenberger, who is the chairman of the Health Subcommittee of the Finance Committee. Many of you may know that Senator Durenberger has been very active in the last several years in health care and also with some emphasis on rural health care.

We are having two hearings, holding them jointly, the first one here today in Billings, and the second one will be in Minnesota, where he and I will again further explore the subject of health care as it applies to rural States and also, generally, the allocation of Federal health care dollars, and particularly financing health care, because that's the jurisdiction for the subcommittee. Frankly, our subcommittee does not have jurisdiction over a lot of primary health programs. That jurisdiction is in the Human Resource Committee of the Senate and the comparable committee in the House. But we have jurisdiction over health financing and the allocation of a lot of Federal dollars.

The hearing this morning will last until approximately 12:30. Senator Durenberger has to catch a plane back to Minnesota, so we want to proceed as quickly, as efficiently, and as effectively as we possibly can. That means we encourage witnesses to immediately get to the point, and, if possible, not to read your statements. I know that's like whistling in the dark; it's wishful thinking. Nevertheless, try to keep your statements down to as short a time as possible. We are going to impose a 10-minute limit, and if it turns out that we're behind time and behind schedule, we might have to ask some later witnesses to testify in a shorter period of time. We'll try to be as flexible and as fair as we possibly can.

Second, we're going to break for a short intermission immediately following the Governor's testimony. There is also the testimony of Dr. Drynan and John LaFaver. The two of them are going back to Helena with the Governor, but, following their testimony will be a short intermission. Perhaps the press wants to ask various questions of the Governor and myself and Senator Durenberger regarding this hearing and, I suppose, some other subjects as well.

It's a pleasure to be here today with many friends. I see many friends here. I know you're here to again tell us what some of the problems are in our State. In Congress, I find a consistent lack of appreciation for health needs that you might expect in the sparsely populated States. I spend a lot of my time trying to convince my colleagues from big cities that solutions to health care problems in Manhattan, N.Y., are not the same as they are in Manhattan, Mont. Increasingly, I think these efforts are reaching some success. For example, for many years, medicare made no allowances for hospitals in small communities. Rather, those hospitals were required to meet the same standards as staffs in larger urban hospitals. Last year we enacted legislation to make these standards more flexible for rural hospitals. In the same way, for many years there was no role for nurse practitioners and physician assistants in medicare, but, again, legislation was enacted, this time, about 3½ years ago, which permits medicare to pay the rural health care clinic for the services of these staff persons. I hope this medicare provision, together with Montana's recently enacted legislation authorizing the use of physician extenders, will help provide medical care in various rural Montana communities suffering a physican shortage.

Another problem in rural areas is that hospitals often lose money because they don't fill enough beds. Last year we enacted what's called a swing bed provision that will greatly help, I think, resolve this problem. This permits small hospitals to use these empty beds for patients needing long-term or nursing home care and still be reimbursed by medicare. This change was designed to make better and more efficient use of small hospitals and to provide badly needed care for the elderly.

These, I think, have been progressive steps, and I am proud that I and Senator Durenberger helped play a role in their development, but despite all the private and governmental actions that have taken place, I think many Montanans still are without quality health care.

For example, 14 percent of our State's population lives in an area that has a shortage of basic medical care. All in all, 83 percent live in areas that lack psychiatric services or other types of somewhat specialized medical care. Every Montanan should have access to medical care, no matter where he or she lives.

The purpose of our hearing today is to explore how this goal can be met and what changes can be made to improve that situation. We'll hear from many witnesses who know firsthand the problems of giving medical care and are on the receiving end of that care. Our witnesses include physicians, nurses, hospital and health clinic administrators, and, of course, those of us who rely on all of these providers of medical care. I look forward to the testimony, and, again, because of the large witness list and large numbers of witnesses and the time constraint that we have, I encourage everyone to keep his or her testimony brief. And, of course, anyone who would like to submit a statement can do so, and the hearing record will be kept open until July 13, so if you have other materials that you wish to submit, I encourage you to submit them, and you have until July 13. Those statements should be sent to my office in Washington.

Again, it's an honor for me to be chairing hearings with Senator Durenberger. We very warmly and cordially extend our hospitality to you, Senator. Some of us in Montana, though, as you know, are engaged in efforts to try to educate you in other areas in addition to rural health care, one of which, which is very dear to our hearts, is the Montana coal severance tax. And, as you know, we, along with the Governor, had a very interesting breakfast together to discuss the severance tax, and I think that was very constructive, and I now know that we don't have you fully persuaded as to the merit of our ways, and we encourage you to back off of the bill, at least until you more deeply understand the practice of our ways.

Basically, I want to thank you. It is very gracious and very generous of you to come before us to discuss this issue.

Senator **Durenberger**. Thanks for breakfast, Max, Governor.

I am going to briefly put myself and my presence here in perspective. As Max indicated, thanks to the election of 1980 and the impact it had on the U.S. Senate, I am chairman of the Health Subcommittee of the Senate Finance Committee. I'm also chairman of the Intergovernmental Relations Subcommittee of the Government Affairs Committee, and that is the area in which, hopefully, we in the Senate are going to play a role in redefining the relationships between the national, State, and local governments and all the private institutions in this country that ought to be delivering services to meet the needs of the people.

This particular issue of access to health care, to me, is the heart of the problem. We wouldn't have demands for national health insurance in this country, and we wouldn't have all the regulatory processes that have developed if the cost of health care in this country had not grown as substantially as it has in the last 20 years. We in the Finance Committee tend to focus a lot on that issue, but there are other issues of access that are even more important that cost, and I think a State like Montana is as good a place to come to examine those issues as any.

And I, even though I come from a more populous State, was born and raised in a little town with fewer than 200 people. I went to a two-room grade school where one teacher taught four grades simultaneously, and I don't know how in the world I ever made it with that crummy education, as they call it now, to the U.S. Senate, but I really do appreciate that the smaller you get, sometimes, and the closer you get to flexibility and innovation the better off you're going to be.

And the Governor will make at least one point in his opening statement, that national health policy proponents have tried to create programs that would benefit the majority of the citizens in this country, but Montana and other rural States have benefited only marginally from these policies. Regulations designed to meet national needs defined by Congress are often irrelevant to the health needs of rural areas.

And that's as good a summary of what brings us to the issue of the future of health policy in this country as any that I can think of. There is no way that we, in our so-called wisdom, in the Congress of the United States can determine how best to meet the very individual needs of people who live in a million different circumstances, economic, social, geographic, and whatnot. The best we can do is to say that this is a standard that ought to be met, and here is our role in finance in getting that standard. But the sooner we get to the point where we leave it to States and local communities and private institutions to decide how those needs are going to be met, the better, and we just started that process this year with the block grants, two of which are in the Finance Committee, social services, title XX, and maternal and child health, which is title V to the Social Security Act. And to a degree, with the changes that we've made in medicare and medicaid, title XVIII and title XIX, we're trying to free the hands of Governors and other people to do the business of determining how people are going to be reimbursed, where they can best have their services met, the whole issue of the future of health service agencies. Community health planning utilization review, appropriateness, review, is all undergoing some change. And I am happy to see that the persons in this State who are responsible for those projects are going to be testifying here today, because change is coming.

The administration sounds like it's going to wipe out a lot of things. It's going to defund the HSA's. It's going to defund PSRO's. I don't necessarily think that's a good idea. I think the idea of some utilization review and some appropriateness review and some form of community health planning is important, but we don't have the answers. You people have the answers to how best to do it, and, Max, that's why I appreciate so much the opportunity that your invitation have given me to be here today and to spend 3 or 4 hours with people that hopefully will have the answers to those problems.

Senator BAUCUS. Thank you, Dave.

Our first witness is the Governor. Ted, come over here.

STATEMENT OF GOVERNOR TED SCHWINDEN, OF MONTANA

Governor SCHWINDEN. Thank you, Max.

Senator BAUCUS. Do you want to be accompanied now, Ted, by Dr. John Drynan and John LaFaver?

Governor SCHWINDEN. Yes; might as well.

Senator BAUCUS. Why don't you two come up, too, John and John.

Let's not go into a long introduction, Ted. We all know who you are.

[The prepared statement of Governor Schwinden follows:]

PREPARED STATEMENT OF GOV. TED SCHWINDEN

Senator Durenberger and Senator Baucus, I would like to thank you for arranging to hold this public hearing in Montana. Please understand at the outset that I am no expert on medicine—for my first 18 years I thought cascara, castor oil, liniment and hot mustard plasters were medicine! Since then, I have come to appreciate more fully the problems of delivering modern health services to rural Montana.

It's very difficult to describe Montana's rural health problems to someone who has never seen the state. Our geography presents some great pleasures and some of our most difficult problems. With ¾ million people sharing 147,000 square miles of mountains, prairies and farmland, Montana's sparsely populated geography presents significant problems in getting health care to the people when and where they need it.

The disparity between rural and urban health care services has been increasing since the turn of the century as the nation has become more urban-oriented.

National health programs have been increasingly geared toward the health needs of urban populations—often at the expense of rural people. For example, a disproportionate amount of funds have been earmarked for urban preventive health care while a person from Jordan, Montana, must travel 83 miles to see a pediatrician or a resident of Lincoln, Montana, must go 56 miles to find the nearest dentist Rising energy, transportation, equipment and personnel costs make health care especially costly for rural Montanans.

Attracting physicians and other health care providers to Montana's rural communities is a continuing problem. Most qualified health care providers would prefer to practice in urban areas with sophisticated equipment in the company of their peers and readily accessible to urban amenities. The image of the "country doc" with his black bag and a horse drawn carriage is now just a memory of days gone by. Today, many rural Montanans must get in their cars and drive many miles to seek medical help in one of the more populated areas. An illustration of the dearth of qualified medical personnel is the fact that Montana now has approximately 900 practicing physicians. That averages out to one doctor for about every 833 people and for every 163 square miles. Some rural communities offer "bonuses" to entice physicians to establish small-town practices but bonuses cannot replace the well-equipped facilities and peer assistance that most doctors appreciate in larger cities and towns.

Emergency transportation of patients in need of medical care is another tough problem for Montanans. Distances and weather often make ground and air transportation both risky and inefficient.

The absence of home health care services in rural areas is another deficiency that deserves attention. Increased home health care services in rural Montana could lower the overall cost of medical care as well as allow persons with long-term illness to convalesce at home.

For the most part, public health services are performed at the county level in Montana. The seven largest counties in the state do have health departments staffed with a full complement of public health workers . . . six of these counties have a full-time director or health officer. Rural counties, however, are at a disadvantage because they cannot afford to fully staff their health departments. If there is a physician in the community, the County Commissioners will appoint him or her as health officer on a part-time basis. Two counties do not have a health officer . . . eight counties lack the services of a public health nurse. If public health services are indeed essential, those services should be reasonably accessible to everyone. Much of rural Montana does not have a fair share of public health services.

The state health department currently provides some services on a direct basis to areas that do not have a health department. For example, a nurse from Helena travels the state screening for hypertension. But the long distances and low staff ratios make that an inefficient way to provide medical services to the public.

National health policy proponents have tried to create programs that would benefit the majority of the citizens in this country. But Montana and other rural states have benefited only marginally from such national policies. Regulations designed to meet national needs defined by Congress are often irrelevant to the health needs of rural areas. Reports, forms and unaffordable requirements impede the delivery of quality health care to rural people. What's good for Harlem and Manhattan, New York is often inappropriate for Harlem and and Manhattan, Montana.

States like Montana are handicapped by the federal practice of using population as a primary factor in determining how to distribute public health dollars to the states. The distances that must be traveled, either by patient or provider are not considered as factors in determining allocations of federal health dollars. We believe "space" should become a component in determining a state's share under formula grant programs.

Given the current status of rural health care in Montana, reports of federal cutbacks in health care funding are met with some apprehension here. If those cutbacks include significant reductions of rural health care dollars, we would be hard pressed to operate with cutbacks of already financially strapped budgets.

I support the Administration's dedication to preventive health care. An "ounce of prevention" should mark our attitudes toward health care in the future. But I hope that the additional federal funds needed to promote that "ounce of prevention" will not be realized by taking a "pound of flesh" from rural health programs.

We must weigh our priorities carefully. As long as rural Americans are still dying because they can't withstand an 80-mile trip to their nearest hospital, the saving of human life must be our top priority. Rural Americans deserve quality health care in order to continue to be productive citizens. Too ensure quality health care in Montana, we must have the ability to adapt federal programs to our unique rural lifestyle.

Governor SCHWINDEN. That's fine. That's great.

Senator BAUCUS. Let's skip the formalities.

Governor SCHWINDEN. Let's try to live with the very admirable time frame that you've set, and I'll try to summarize, which is, I think, what you want done.

I first of all want to thank you, Max.

Senator Durenberger, I welcome you into the State. I always wanted to know the difference between a Democratic Governor and a Republican Senator, and obviously it's that you went to a two-room, one-room school, and I went to a one-room school where they taught all eight grades.

I think in fairness to the Senator, too, we should also say that part of our discussion this morning concerned the high level of sensitivity which Senator Durenberger has regarding the transportation requirements of the Upper Midwest, which include not only Montana but, of course, his own State of Minnesota.

It's not true in Senator Durenberger's case, and obviously not in your case, Max, but to describe Montana's rural health problems to anyone who has never seen a rural and sparsely populated Western State, is very difficult. We have some three-quarters of a million people in about 150,000 square miles of mountains, prairies, and farmlands. Interestingly, that's almost exactly the size of the entire country of Japan; just about 100 million acres and less than one-hundredth of the population. That sparse population raises the very significant problems of getting health care to the people who need it. The disparity has been increasing as our country becomes more and more urban and we become more and more rural islands in a national urban sea.

And as you've already read from my testimony Senator Durenberger, the national health programs have been geared more and more toward urban populations out of a national concern, sometimes at the expense of rural people. The distances that need to be traveled sometimes can get staggering. If you live in Jordan, you have to go about 83 miles to see a pediatrician.

Rising energy, transportation, and other costs impact the rural population very seriously. Attracting medical people, physicians, for example, to Montana rural communities is a very real problem in communities like the one that I call my hometown.

Montana has now some 900 practicing physicians. That's about 1 for 830 people, but, more interestingly, it's one for every 163 square miles. That's a lot of territory.

The bonus practice is quite common in Montana where small towns offer various kinds of incentives or lures, but bonuses really don't replace the well-equipped facilities and peer assistance that most doctors appreciate in Montana's larger cities and towns.

Particularly acute is the assistance of home health care services in rural areas, because of the obvious benefits of those kinds of programs. If we could increase the level of those kinds of services in rural Montana, I am confident that we could not only lower the overall cost of medical care but allow some people with long-term mental illness to stay at home and convalesce there.

I'm sure Dr. Drynan will discuss our health delivery system at the State level and paint again a picture of the disparity between rural and what we call urban counties even within Montana. We have two counties that don't have a health officer. Eight of our counties lack the services of a public health nurse. If public health services are indeed essential, and, of course, they are, those services should be reasonably accessible to everyone.

You've already read the next statement. As the Congress and the successive administrations have tried to put together health policy programs in the national public interest, rural States have often benefited only marginally, and, in some cases, we've had real problems in terms of the regulations. What's good for Manhattan and Harlem, N.Y., often is totally inappropriate for Harlem and Manhattan, Mont.

States like Montana are handicapped by the Federal practice of using population as a primary factor. Space, we think, should also become a component in that very difficult process of trying to determine equity in any allocation of Federal funding and formula grant programs.

Given the current status of rural health care in Montana, we're concerned about cutbacks in Federal budgets in those areas. If they mean significant reductions of rural health care dollars, we're going to be hard pressed to meet those requirements with our already financially strapped budgets. We're going to have to weigh our priorities very carefully.

Rural people deserve the same quality health care that other people do if they're going to continue to be productive citizens. Montanans must have the ability to adapt those Federal programs to our very unique lifestyles out here.

I am very pleased to present the next two gentlemen. For your information, Senator Durenberger in particular, Dr. Drynan is unuaual in his responsibilities. When he came to my administration in January, he was a hands-on physician, and had been spared the travails of bureaucracy until January, when he agreed to come aboard our administration.

Mr. LaFaver had an interesting background as the director of our department of social and rehabilitation services. He brings some 6 or 7 years of service as a legislative fiscal analyst, and so is very acutely aware of the legislative kinds of concerns associated with the establishment of priorities and the ever-increasing budgetary problems that both your Congress and our legislature face, and I am very pleased—I don't remember who is first on the list.

Senator **Baucus**. Dr. Drynan is first, but whichever of the two you'd like.

STATEMENT OF JOHN J. DRYNAN, M.D.

Dr. **Drynan**. Senator Baucus and Senator Durenberger, thank you for the opportunity to testify before this committee. I have sent prepared statements to you.

[The prepared statement of Dr. Drynan follows:]

Prepared Statement of John J. Drynan, M.D.

Less than a hundred years ago Montana was still the frontier. The country doctor riding endlessly through vast stretches of wild country to treat patients was as common as patients traveling equally difficult miles to see the physician.

Since the great rush of settlers into Montana in the late 1800's, Montanans have always placed a high value on obtaining the best medical care possible. This concern led to the creation of the State Board of Health by the Seventh State Legislative

Assembly in 1901, 12 years after statehood had been granted to the 147,138 square miles of plains, rolling hills and moutains.

From its incpetion the Montana Department of Health and Environmental Sciencies (DHES) and Board of Health and Environmental Sciences (BHES) have been the conduit through which Montanans have worked to bring progressive health care to the state. The quest to provide the best health care possible, has made Montana a leader in such areas as discovering the cure for Rocky Mountain Spotted Fever, creating and enforcing progressive drinking water standards, establishing an effective program to ensure infant and maternal health care and establishing effective preventive health measures.

Today Montanans enjoy many of society's modern benefits, however Montana's strength still comes from the land. Farming and ranching families living far from small rural communities remain distinctive and integral parts of the state's life style.

Being rural and progressive, Montanans are still striving to improve health care for those living far from urban medical centers. The horse-drawn carriage with the weary country doctor is gone, but the problem remains; how can rural families receive good clinical and emergency medical service?

The creation of rural clinics with emergency medical service capabilities would fill a void that continues to plague Montana and other rural states throughout the nation. People living in rural areas simply don't have anything to compare with well-equipped and staffed urban clinics. Additionally, nowhere in rural America is there an effective program for providing rapid, effective emergency medical service.

Montana's proposed solution to the problem would involve federal assistance to state and local health agencies in developing regional rural clinics with emergency medical service capabilities to see if the concepts could be successfully implemented throughout the nation.

To fully understand why there are problems providing good medical care to rural Americans, three basic elements must be discussed: Accessibility, availability, and acceptability.

For Americans who live west of the Mississippi River, accessibility means only one thing—distance. For Montanans distance is part of the fabric of life. Most talk in terms of hours rather than miles.

To the rural farmer or rancher, illness and transportation to a place where he or she can be properly treated is not much different than it was for their grandparents. Medically, the sooner a person is treated, the better their chances for a full and rapid recovery, but often just getting to the doctor becomes a major undertaking.

Some of the practical considerations rural people face when planning a trip to a medical center include: (a) finding someone to care for the farm or ranch, (b) arranging for child care, (c) finding the time to make the trip, (d) dealing with natural elements, especially in the winter (e) making arrangements for food and lodging, (f) making the trip, and (g) travel, food and lodging costs.

The availability of medical care for rural persons must be inventoried. Montana's medical needs relating to health facilities and providers need to be inventoried as to their locations and capabilities commensurate with the population they serve. Subsequently, suitable and accessible locations with health professionals in attendance can be identified and encouraged. Physical locations for health care should then serve isolated people in the smaller populated counties, enabling them to receive the best health service possible. The centralized locations would also meet their needs with regards to distance and time to available and acceptable health care.

By establishing these health care facilities, health care could be provided earlier, thus decreasing cost by early diagnosis and treatment. Further, the rural populace would be more apt to use health care facilities as a preventive tool by more routine examination and followup, which, over the long haul, translates into earlier detection and treatment of illnesses, thus reducing cost by quicker recovery and shorter hospitalization.

Over-utilization of health care, primarily an urban problem, is not likely to develop because the rural patient will still have to encounter greater distance, time and hardships, which usually lends itself to the truly needy visits.

Physician coverage of the less populated areas of Montana is small when compared to the number of persons served and the square miles of territory needed to be covered. As a result, a doctor is often busy with another case when emergencies arise. The result from being unable to give immediate attention to the problem is increased risks for patients. Physicians also may be out of the area, ncessitating further travel and risk for the rural patient to acquire health care.

If nurse practitioners and/or physician assistants were available, this would help alleviate much of our rural health care problem. However, to be successful, they must be under the direct supervision of a sponsoring physician. The problems here are many. First, personal physician malpractice insurance coverage would be more due to the increased potential for being sued. The Congress could help by addressing this ever-growing problem and possibly setting guidelines, financial rates and ceilings and claims or insurance assistance with a federal policy to compensate for the increased risk.

Second, communication with the sponsoring physician is imperative. A telecommunications system would be the most ideal, but totally out of reach economically for local or state governments to provide. A radio network could be employed, much like that used by Emergency Medical Services, but again, federal assistance would be needed. In other words, a communications system has to be in place where 24-hour interchange is available, and a simple telephone will not solve this problem.

Thirdly, we need suitable in-state teaching facilities to educate and develop the physician assistants and nurse practitioners. We can't continue to rely on other states to fulfill this need for us and themselves. Federal grants in education would help establish and maintain such an educational facility in existing Montana unversities.

Fourth, an increased effort is needed to equip each county with trained, certified emergency medical service technicians and ambulances to respond to the county-wide emergencies. Again, cost in a factor and without federal assistance, this will never happen since neither state nor local government has the magnitude of resources needed to accomplish this task. In addition, this would not only benefit Montana's citizenry, but would be advantageous to tourism, thus benefiting many others.

Finally, in terms of acceptability, we must educate our public and demonstrate to them that the health care provided for them in their area is competent, efficient, convenient and cost effective. We must demonstrate to them that we can provide care and want to respond to their needs.

We propose that grant monies be extended to Montana to inventory the existing health providers and facilities in the 56 counties, that inventory to be so minute that definitions of provider and facility be established within that county.

From that inventory, it could be determined whether a town such as Troy, Montana needs medical aid at the Emergency Medical Training level or if Libby, Montana needs medical capabilities at the diagnostic and emergency training levels.

We propose that grant monies to assist with the establishment of these facilities be provided. Grant services would be needed to help with salaries, as rural health clinics would not generate enough financial profit over cost to attract, compensate, and keep the trained personnel, including, in some areas, a physician. Resources for on-going training and continued education to keep abreast in the health care area should be provided for.

Communication network and equipment funding is needed. We propose this be state-wide since Montana has diversification such that results in a mountain valley may apply to West Virginia and results from the flowing grainfields may apply to North Dakota, both states from folklore jokes need help.

Legislation to mitigate malpractice situations, especially as related to nurse practitioners and/or physician assistants, needs to be enacted.

Finally, we propose to the federal government that all waivers necessitated from the inventory be extended to those counties in Montana by the Secretary of Health and Human Services with the understanding that the definition of health provider and health facility vary tremendously in rural areas. This proposal recognizes that the State of Montana requirements must be altered along with the federal waivers that reflect into malpractice requirements and costs.

Montana, for its part, if encouraged as to possibilities of the proposal, will call all medical discipline representatives together to assure full cooperation to institute the proposal, to assure peer review of each discipline, and the interface of provider and consumer that is essential to provide the final result that has evaded America for forty years; urban health assurance to rural inhabitants.

In conclusion, I believe it is imperative that we in America ensure the same quality of health care, one that is easily accessible, one that is easily available, one that is assuredly acceptable, to rural citizens as it is for urban populations.

If we expect rural America to continue as an active producer for urban populations, if urban populations in America desire to continue enjoying the positive life style to which we have become accustomed, it is imperative that we afford the same quality of health care to rural citizens as we enjoy in our urban societies.

Dr. **Drynan**. In summary of the presentation, today Montanans enjoy many of society's modern benefits. However, Montana's strength still comes from the land. Farming and ranching families living far from small rural communities remain distinctive and integral parts of the State's lifestyle.

Being rural and progressive, Montanans are still striving to improve health care for those living far from urban medical centers. The horse-drawn carriage with the weary country doctor is gone, but the problem remains; how can rural families receive good clinical and emergency medical service?

The creation of rural clinics with emergency medical service capabilities would fill a void that continues to plague Montana and other rural States throughout the Nation. People living in rural areas simply don't have anything to compare with well-equipped and staffed urban clinics. Additionally, nowhere in rural America is there an effective program for providing rapid, effective emergency medical service.

Montana's proposed solution to the problem would involve Federal assistance to State and local health agencies in developing regional rural clinics with emergency medical service capabilities to see if the concepts could be successfully implemented throughout the Nation.

To fully understand why there are problems providing good medical care to rural Americans, three basic elements should be addresed or discussed, and they are accessibility, availability, and acceptability of medical care.

For Americans who live west of the Mississippi River, accessibility means only thing—distance. For Montanans, distance is part of the fabric of life. Most talk in terms of hours rather than miles.

To the rural farmer or rancher, illness and transportation to a place where he or she can be properly treated is not much different than it was for their grandpartents. Medically, the sooner a person is treated, the better their chances for a full and rapid recovery, but often just getting to the doctor becomes a major undertaking.

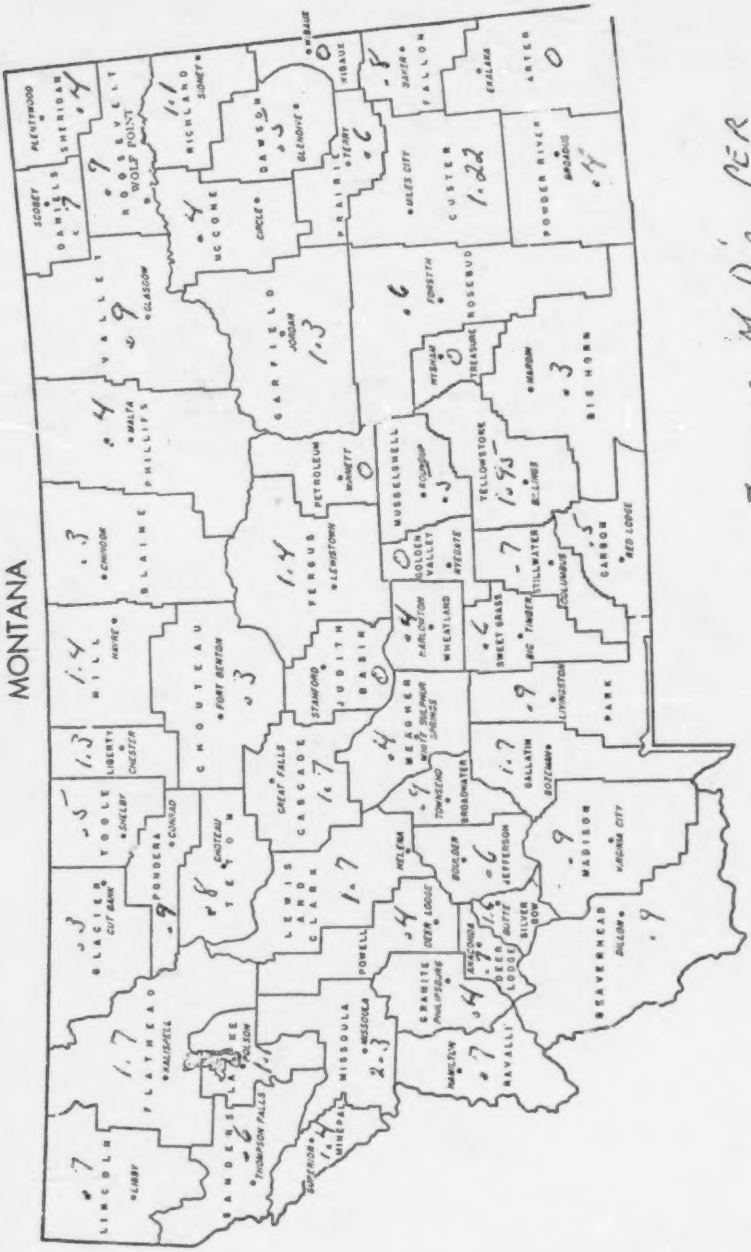
Some of the practical considerations rural people face when planning a trip to a medical center include: One, finding someone to care for the farm or ranch; two, arranging for child care; three, finding the time to make the trip; four, dealing with natural elements, especially in the winter; five would be making arrangements for food and lodging; six would be making the trip; and, seven, travel, food, and lodging costs.

The availability of medical care for rural persons must be inventoried. Montana's medical needs relating to health facilities and providers need to be inventoried as to their locations and capabilities commensurate with the population they serve. Subsequently, suitable and accessible locations with health professionals in attendance can be identified and encouraged. Physical locations for health care should then serve isolated people in the smaller population counties, enabling them to receive the best health service possible. The centralized locations would also meet their needs with regards to distance and time to available and acceptance health care.

By establishing these health care facilities, health care could be provided earlier, thus decreasing cost by early diagnosis and treatment. Further, the rural populace would be more apt to use health care facilities as a preventative tool by more routine examination and followup, which, over the long haul, translates into earlier detection and treatment of illnesses, thus reducing cost by quicker recovery and shorter hospitalization.

Overutilization of health care, primarily an urban problems is not likely to develop because the rural patient will still have to encounter greater distance, time, and hardships, which usually lends itself to the truly needy visits.

Physician coverage of the less populated areas of Montana is small when compared to the number of persons served and the square miles of territory needed to be covered, as the Governor has alluded to. With this testimony I have provided are maps that show the percentage of doctors per thousand population and the numbers of doctors actually in the counties of the State of Montana. If you'll look at those maps, if you get a chance, you'll notice there are four counties with no doctors in the State of Montana, and they're isolated areas of travel for those people. As a result of this, physician coverage of the less populated areas of Montana is small when compared to the number of persons served in the square miles of territory needed to be covered. As a result, a doctor is often busy with another case when emergencies arise. The result from being unable to give immediate attention to the problem is increased risks for patients. Physicians also may be out of the area, necessitating further travel and risk for the rural patient to acquire health care.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FALLON .8
CUSTER 1.22
CARTER 0
POWDER RIVER .4
ROSEBUD .6
TREASURE 0
BIG HORN .3
YELLOWSTONE 1.95
MUSSELSHELL .3
PETROLEUM 0
FERGUS 1.4
CHOUTEAU .3
PONDERA .9
TETON .8
CASCADE 1.7
JUDITH BASIN 0
WHEATLAND .4
GOLDEN VALLEY 0
MEAGHER .4
LEWIS AND CLARK 1.7
BROADWATER .4
SWEET GRASS .6
STILLWATER .7
CARBON .5
PARK .9
GALLATIN 1.7
JEFFERSON .6
MADISON .9
BEAVERHEAD .9
SILVER BOW 1.6
DEER LODGE .7
POWELL .4
GRANITE .4

Active M.D.'s per
1000 Population
May, 1981

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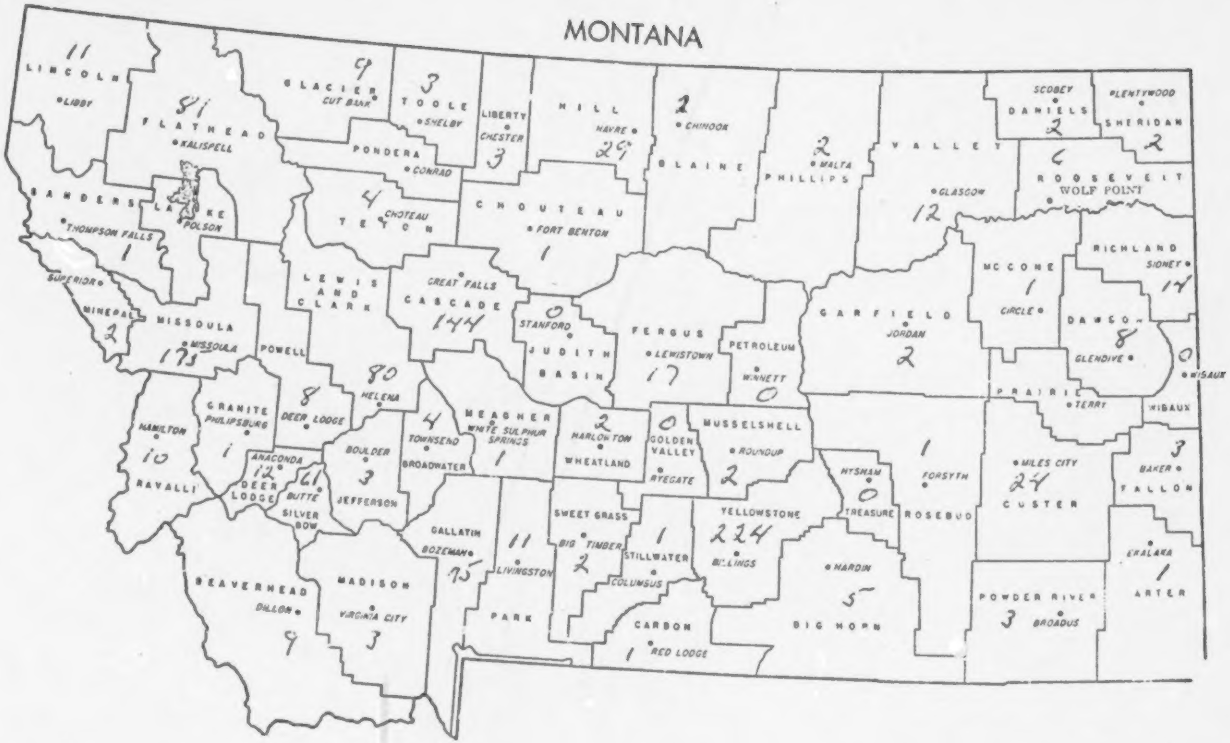
MONTANA
LINCOLN 11 Libby
FLATHEAD 81 Kalispell
GLACIER 9 Cut Bank
TOOLE 3 Shelby
LIBERTY Chester 3
HILL Havre 29
BLAINE 2 Chinook
PHILLIPS 2 Malta
VALLEY Glasgow 12
DANIELS Scobey 2
SHERIDAN Plentywood 2
ROOSEVELT 6 Wolf Point
SANDERS Thompson Falls 1
LAKE Polson
PONDERA Conrad
TETON 4 Choteau
CHOUTEAU Fort Benton 1
RICHLAND Sidney 14
MINERAL Superior 2
MISSOULA Missoula 175
LEWIS AND CLARK 80 Helena
CASCADE Great Falls 144
JUDITH BASIN 0 Stanford
FERGUS Lewistown 17
PETROLEUM Winnett 0
GARFIELD Jordan 2
McCONE 1 Circle
DAWSON 8 Glendive
WIBAUX 0 Wibaux
POWELL 8 Deer Lodge
GRANITE Philipsburg 1
RAVALLI Hamilton 10
DEER LODGE Anaconda 12
SILVER BOW Butte 61
JEFFERSON Boulder 3
BROADWATER 4 Townsend
MEAGHER White Sulphur Springs 1
WHEATLAND 2 Harlowton
GOLDEN VALLEY 0 Ryegate
MUSSELSHELL Roundup 2
TREASURE Hysham 0
ROSEBUD 1 Forsyth
CUSTER Miles City 24
PRAIRIE Terry
FALLON 3 Baker
CARTER Ekalaka 1
BEAVERHEAD Dillon 9
MADISON Virginia City 3
GALLATIN Bozeman 75
PARK 11 Livingston
SWEET GRASS Big Timber 2
STILLWATER 1 Columbus
YELLOWSTONE 224 Billings
CARBON 1 Red Lodge
BIG HORN Hardin 5
POWDER RIVER 3 Broadus

ACTIVE M.D.'s PER
COUNTY (MMA STATS
FOR 1981) ALL SPECIALTIES.

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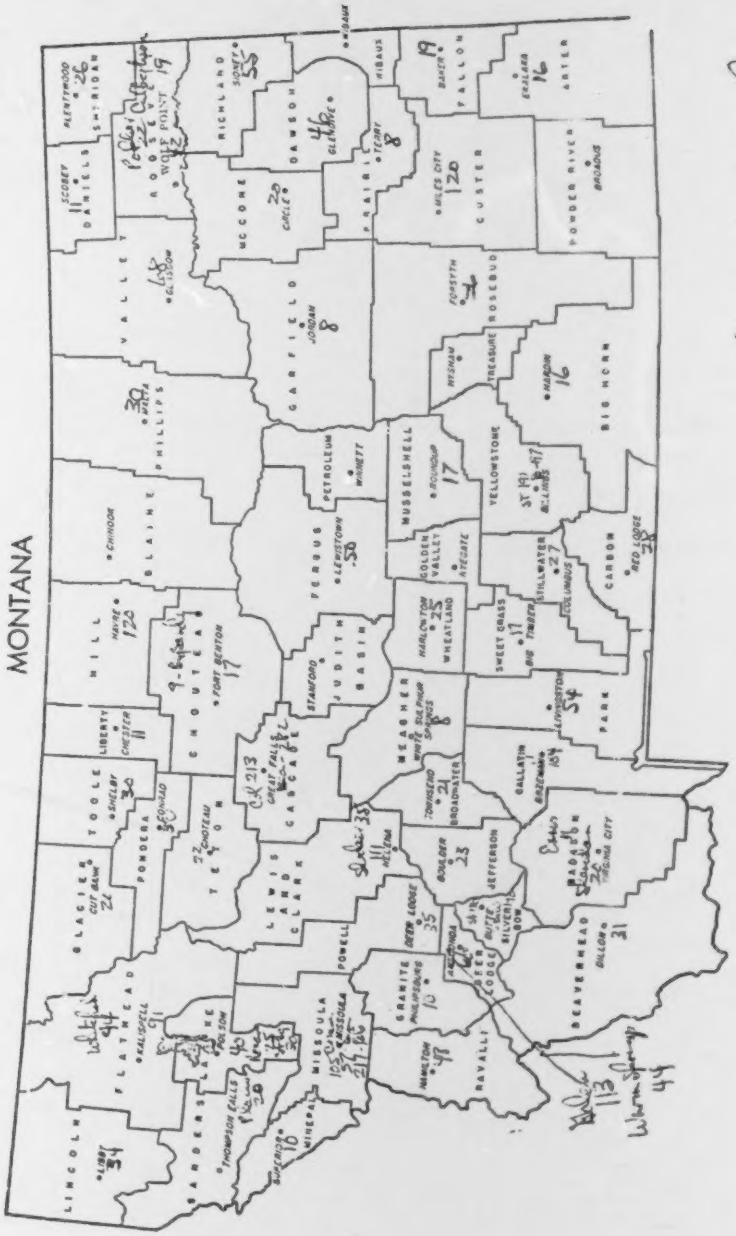
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CUT BANK 22
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SHELBY 30
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CHESTER 11
HILL
HAVRE 120
BLAINE
CHINOOK
PHILLIPS
MALTA 30
VALLEY
GLASGOW 68
DANIELS
SCOBEY 11
SHERIDAN
PLENTYWOOD 26
ROOSEVELT
WOLF POINT
Culbertson 19
RICHLAND
SIDNEY 55
DAWSON
GLENDIVE 46
WIBAUX
McCONE
CIRCLE 20
GARFIELD
JORDAN 8
PRAIRIE
TERRY 8
FALLON
BAKER 19
CARTER
EKALAKA 16
CUSTER
MILES CITY 120
POWDER RIVER
BROADUS
ROSEBUD
FORSYTH
TREASURE
HYSHAM
BIG HORN
HARDIN 16
YELLOWSTONE
BILLINGS
ST 191
CARBON
RED LODGE 28
STILLWATER
COLUMBUS 27
MUSSELSHELL
ROUNDUP 17
GOLDEN VALLEY
RYEGATE
PETROLEUM
WINNETT
FERGUS
LEWISTOWN 50
JUDITH BASIN
STANFORD
WHEATLAND
HARLOWTON 25
SWEET GRASS
BIG TIMBER 17
PARK
LIVINGSTON 54
GALLATIN
BOZEMAN 104
MEAGHER
WHITE SULPHUR SPRINGS 8
CHOUTEAU
FORT BENTON 17
9 Big Sandy
CASCADE
GREAT FALLS
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TETON
CHOTEAU 22
PONDERA
CONRAD 30
LEWIS AND CLARK
HELENA 111
BROADWATER
TOWNSEND 21
JEFFERSON
BOULDER 23
MADISON
VIRGINIA CITY
Ennis
Sheridan 22
BEAVERHEAD
DILLON 31
SILVER BOW
BUTTE
DEER LODGE
ANACONDA
GRANITE
PHILIPSBURG 10
POWELL
DEER LODGE 35
MISSOULA
MISSOULA
MINERAL
SUPERIOR 16
SANDERS
THOMPSON FALLS
Plains 20
LAKE
POLSON
RAVALLI
HAMILTON 48
Helena 113
Warm Springs 44

Hospitals Beds
1981

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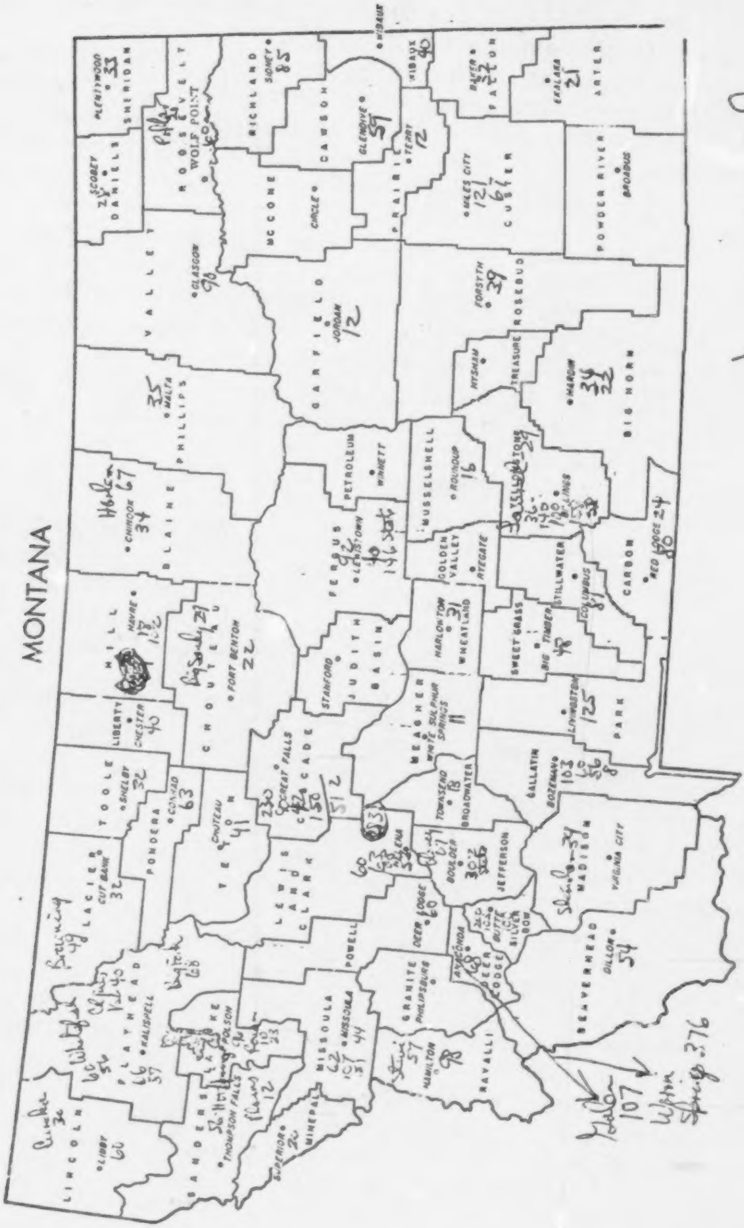
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RAVALLI
HAMILTON
GRANITE
PHILIPSBURG
POWELL
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MEAGHER
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FORT BENTON
JUDITH BASIN
STANFORD
WHEATLAND
HARLOWTON
SWEET GRASS
BIG TIMBER
STILLWATER
COLUMBUS
CARBON
RED LODGE
GOLDEN VALLEY
RYEGATE
MUSSELSHELL
ROUNDUP
YELLOWSTONE
BILLINGS
FERGUS
LEWISTOWN
PETROLEUM
WINNETT
BLAINE
CHINOOK
PHILLIPS
MALTA
VALLEY
GLASGOW
DANIELS
SCOBEY
SHERIDAN
PLENTYWOOD
ROOSEVELT
WOLF POINT
RICHLAND
SIDNEY
MCCONE
CIRCLE
GARFIELD
JORDAN
DAWSON
GLENDIVE
PRAIRIE
TERRY
WIBAUX
FALLON
BAKER
CUSTER
MILES CITY
ROSEBUD
FORSYTH
TREASURE
HYSHAM
BIG HORN
HARDIN
POWDER RIVER
BROADUS
CARTER
EKALAKA

Nursing Home Beds
1951

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One of the solutions would be, as we alluded to, is the nurse practitioner and the physcian assistance act, to make them available. There is a real problem in the State of Montana with this. The problem arises with the sponsoring physician.

First, personal physician malpractice insurance coverage would be more due to the increase potential for being sued. The Congress could help by addressing this ever-growing problem and possibly setting guidelines, financial rates, and ceilings on claims for insurance assistance with a Federal policy to compensate for the increased risk.

Another problem is communication with the sponsoring physician, which is imperative. A telecommunications system would be the most ideal, but totally out of reach economically for local or State governments to provide, especially in the lower population States. A radio network could be employed, much like that used by Emergency Medical Services, but again, Federal assistance would be needed. In other words, a communications system has to be in place 24 hours a day so that interchange is available between physician assistant and sponsor, and simple telephone will not solve this problem.

Third, we need suitable in-State teaching facilities to educate and develop the physician assistants and nurse practitioners. We can't continue to rely on other States to fulfill this need for us and themselves. Federal grants in education would help establish and maintain such an educational facility in existing Montana universities.

Fourth, an increased effort is needed to equip each county with trained, certified emergency medical service technicians and ambulances to respond to the countywide emergencies. Again, cost is a factor, and without Federal assistance, this will never happen, since neither State nor local government has the magnitude of resources needed to accomplish this task. In addition, this would not only benefit Montana's citizenry, but all citizenry of the United States traveling through here as tourists.

Finally, in terms of acceptability, we must educate our public and demonstrate to them that the health care provided for them in their area is competent, efficient, convenient, and cost effective. We must demonstrate to them that we can provide care and want to respond to their needs.

We propose that grant moneys be extended to Montana to inventory the existing health providers and facilities in the 56 counties, that inventory to be so minute that definitions of "provider" and "facility" be established within that county.

From that inventory, it could be determined whether a town such as Troy, Mont., need medical aid at the emergency medical training level, or if Libby, Mont., needs medical capabilities at the diagnostic and emergency training levels.

We propose that grant moneys to assist with the establishment of these facilities be provided. Grant services would be needed to help with salaries, as rural health clinics would not generate enough financial profit over cost to attract, compensate, and keep the trained personnel, including, in some areas, a physician. Resources for ongoing training and continued education to keep abreast in the health care area should be provided for in small populace States.

Communication network and equipment funding is needed. We propose this be statewide since Montana has diversification such that results in a mountain valley may apply to West Virginia and results from the flowing grainfields may apply to North Dakota and Minnesota; both States from folklore jokes need help.

Legislation to mitigate malpractice situations, especially as related to nurse practitioners and/or physician assistants, needs to be enacted.

Finally, we propose to the Federal Government that all waivers necessitated from the inventory be extended to those counties in Montana by the Secretary of Health and Human Services with the understanding that the definition of "health provider" and "health facility" vary tremendously in rural areas. This proposal recognizes that the State of Montana requirements must be altered along with the Federal waivers that reflect into malpractice requirements and costs.

Montana, for its part, if encouraged as to possibilities of the proposal, will call all medical discipline representatives together to assure full cooperation to institute the proposal, to assure peer review of each discipline, and the interface of provider and consumer that is essential to provide the final result that has evaded America for 40 years: urban health assurance to rural inhabitants.

In conclusion, I believe it is imperative that we in America insure the same quality of health care, one that is easily accessible, one that is easily available, and one that is assuredly acceptable, to rural citizens as it is for urban populations.

If we expect rural America to continue as an active producer for urban populations, if urban populations in America desire to continue enjoying the positive lifestyle to which we have become accustomed, it is imperative that we afford the same quality of health care to rural citizens as we enjoy in our urban societies.

Senator BAUCUS. Thank you very much, Dr. Drynan.

The next witness will be John LaFaver, who is the director of SRS.

STATEMENT OF JOHN D. LaFAVER, DIRECTOR OF SRS

Mr. LAFAVER. Thank you, Senator.

I appreciate the opportunity to be here this morning. I prepared a statement, and that's a part of the record, and I won't reiterate that this morning.

[The prepared statement of Mr. LaFaver follows:]

PREPARED STATEMENT OF JOHN D. LAFAVER

The ideal health care system is one is which quality services are available to individuals regardless of the happenstance of their living in Boston or in Baker, Montana. The bottom line is the delivery of services, and the system we now have falls for short of this basis goal.

Physicians in rural areas tend to be in solo practice and are usually extremely busy. It is difficult for them to keep their knowledge current. The physician population of rural America is typically older general practitioners who are not being replaced by younger physicians. Several studies indicate that rural health care professionals often lack the resources to provide minimal patient care. The question of course is whether some care is better than no care. Attention has been given to preventive services in the treatment of chronic illnesses in rural areas. The level of chronic illness in the population in general and especially in rural areas is growing.

Health status measurements such as mortality and life span are generally not as good and reflect the disparity between rural areas and the population at large. Allied health professionals are virtually nonexistent in many rural areas. In Montana, there are only a handful of full-time local public health departments.

These characteristics of rural health care are exacerbated in a highly rural state like Montana. Even most Montanans cannot really appreciate the sheer size and relative lack of population in this state. The eastern third of Montana, for example, is an area the size of Pennsylvania with a total population of 100,000. This is a much different kind of rural area than rural Kansas or rural Alabama. The problems of providing health care in this environment are truly monumental.

The federal role in rural health has been primarily derivative from urban health policies and programs. These programs are suitable when there are a variety of specialized physicians, large hospitals, allied health professionals, and active public health departments. Most of these services simply are not available in most areas of Montana.

Many federal programs in health care are heavily process oriented. We can count users, encounters, compliance with turn-around times; and we can receive a very good score for these kinds of process criteria. They do very little good, however, when the patient or the client does not have access to basic health care. These process criteria have evolved into a maze of regulations, conflicting mandates, and overlapping jurisdictions. The federal, state, and local bureaucracies have been burdened with what has been described as "bean counting." These time consuming and often meaningless forms, reports, and requirements are costly and drain considerable talent and effort away from the primary mission of delivering quality health care to people in rural areas.

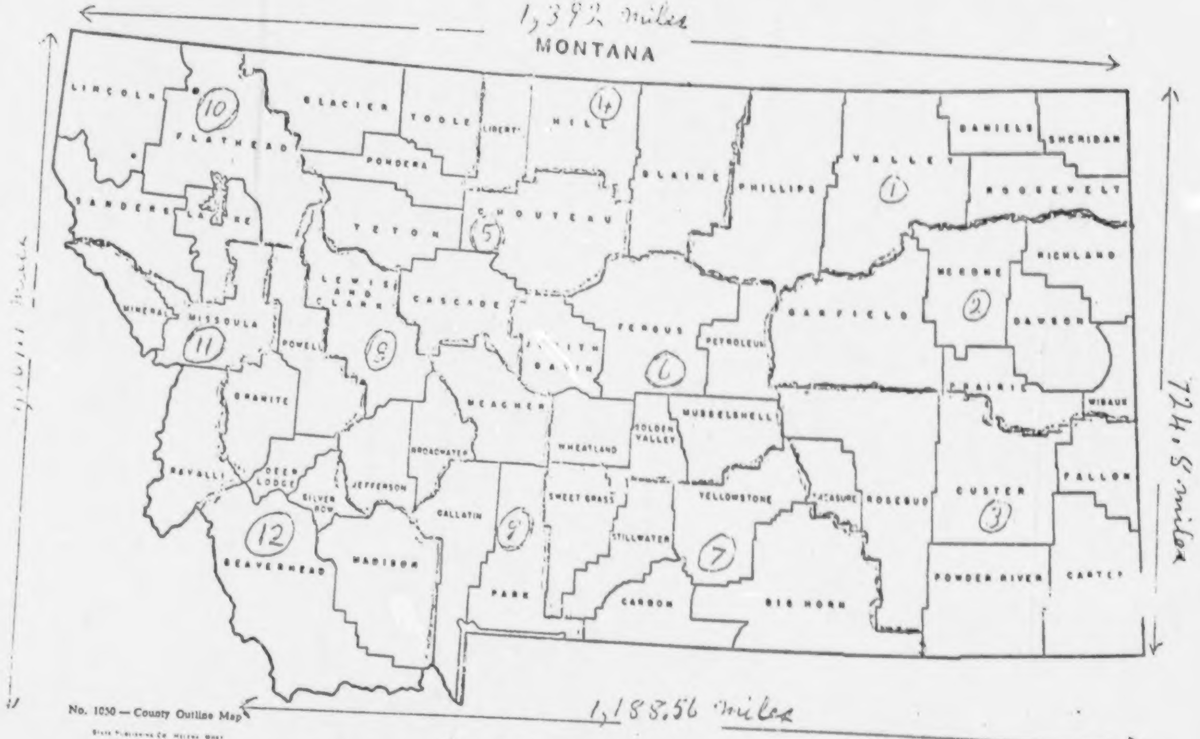
The billions of dollars spent federally in health care have contributed to the dramatic increase in the cost of health care. This increased cost has placed a disproportionate burden on rural states which do not have the population or the resources of larger states. The proposals of the current administration to reduce federal involvement in health care will similarly impose a disproportionate burden on rural states. The withdrawal of federal support for health care should not go unchallenged.

One potential solution to some of these problems is the current bloc grant proposal that would allow states the discretionary authority to allocate federal funds to meet their own particular health care needs. Part of what we see happening, however, is that the budgetary process for bloc grants is proceeding without the requisite change in regulatory requirements. Rules and regulations for categorical grants will still be in effect despite being funded through a bloc grant mechanism at a lower rate. It is, therefore, the worst of both worlds. States are expected to operate rural health care services with across the board reductions while still subject to the various federal rules and regulations.

Nationally, there is very little awareness of the problems of rural health and rural health care. As a result, there is relatively little influence to sway federal policy. The problems of rural health will continue to grow. Financial resources must be available to meet the needs and to provide the basic services required for our rural areas. And, these financial resources must be made available in a manner that can be efficiently managed and utilized for services. This is quite a large order of business: (1) federal support for rural health cannot be arbitrarily withdrawn without rather severe consequences. The limited services we are now able to provide in many rural areas would collapse without federal financial assistance. The rural health care system we have created over the past several years would not be able to survive. There are no replacement alternatives to this rural health system. (2) Federal assistance must be provided in a manner that replaces the current system of regulatory and administrative mandates with a coherent system of efficient management and utilization of federal health care dollars.

We have appreciated your efforts in support of rural health in the past, and we would urge you to continue your initiatives in attempting to make possible quality health care in the rural areas of Montana and elsewhere in the nation.

(Attachment A)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724.8 miles
1,188.56 miles
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YELLOWSTONE
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ROSEBUD
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POWDER RIVER
BIG HORN
CARBON
PARK
MADISON
BEAVERHEAD
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12
No. 1030 — County Outline Map

MSCA MULTI-COUNTY DISTRICTS

① District Number
Board Member Districts

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[Attachment B]

RESOLUTION NO. 17, MONTANA HEALTH SYSTEMS AGENCY

Adopted: MSCA. The HSA has the potential of providing a way for the people to cooperate with the providers of health services to make good health services available to all the people at a price that is reasonable.

Many consumers are spending long hours and traveling great distances to do their share in making the program work. A good number of providers are also trying hard to cooperate in this effort. The members of the Montana HSA Executive Committee, are really sincere in their desire to make HSA a success, are faithful in attending the meetings, studying the applications, open minded in the discussions, and conscientious in their voting.

There are many roadblocks to success:

(1) The hospitals, nursing homes and doctors have been all powerful and enjoyed great prestige for many years and don't want to share their power.

(2) Consumers have become meek, faced with providers. Consumers have difficulty with understanding medical jargon.

(3) Hospital administrators have been happy to accept government money, but have an irrational hatred for government regulations.

(4) Sparce population and great distances make health services unequally distributed with few services available in rural and small town areas.

(5) Too often an overworked small town doctor is jealous and uncooperative when a much needed second doctor tries to get established.

(6) Jealousy and rivalry between two hospitals in one city or near-by cities results in duplication of very expensive services that could be provided more efficiently if the hospitals would plan together with one investing in one special service and the other choosing to specialize in another.

(7) Although consumers by law have a majority in membership in HSA, the long distances to meetings makes it difficult to attend, so there often are more providers than consumers.

(8) There is still not a good procedure for electing consumers to the Boards and committees.

(9) Many hours of home work are required to study the many applications and other necessary papers in order to make the fair decisions.

(10) It is almost impossible for the general public to learn about HSA.

Needed improvements:

(1) Publicity—when HSA functions well it doesn't make the news. The news is about the providers opposition to HSA. Efforts could be made to get sub area council members on local TV and radio frequently as members of other organizations do.

(2) HSA board and council members should be invited to speak at service organization meetings to spread the word about the potential good of HSA.

(3) Consumer group action is essential for success of HSA. If possible such groups should be formed. Or as an alternative an active committee could be formed in each already functioning group as farmer's union local, and county organizations, churches, services clubs, etc. They should nominate their candidate to run for election to the sub area councils of HSA and other health systems boards; publicize the dates of the meetings and arrange car pools to attend. They should keep their group up to date on pending legislation about HSA and other health services and send letters and telegrams to their Congressmen and Senators and State legislators and to the President of the United States of America.

[Attachment C]

FORTUNE'S "500" LIST SHOWS THAT ENERGY FIRMS DID EXCEEDINGLY WELL IN 1980; GAINED IN RANKINGS

Fortune magazine's annual compilation of the 500 largest industrial corporations in the U.S., issued last week, indicates that petroleum refiners hold four of the first five top spots and 13 out of the top 20 positions. In 1980, Exxon had a total of $103 billion in sales, an increase of 30 percent over a year earlier. Mobil Oil moved into the number two spot with sales of $59.5 billion, a 33 percent increase over 1979. General Motors, the perennial leader of the Fortune 500, which dropped to second place in 1979, dropped to third place in 1980. Texaco is now in the fourth place with $51.1 billion in sales, a 33 percent increase for the year. Standard Oil of California ranks fifth with $40.4 billion in sales, a 38 percent increase. Gulf Oil ranked seventh, with $26.4 billion in sales volume, a 10 percent gain. Standard Oil of Indiana ranked ninth with $26.1 billion in sales, a gain of 40 percent.

With only two exceptions, the major oil refiners earned net income of more than 20 percent on stockholders' equity in 1980, with Mobil enjoying the best rate with 25 percent.

A total of 50 food companies are on the Fortune 500 list, some of them strictly in food products, but others conglomerates with other major lines. Topping the food firms are Dart & Kraft with $9.4 billion in sales, Beatrice Foods with $8.2 billion, Esmark with $6.1 billion, General Foods with $5.9 billion and Consolidated Foods with $5.3 billion.

The next five include Ralston Purina with $4.8 billion, Greyhound with $4.7 billion, Iowa Beef Processors with $4.6 billion, Bordens with $4.5 billion and General Mills with $4.1 billion.

OIL PROFITS SOAR AGAIN

The oil industry's take in 1980 was over $30 billion—1979's record profits. This figure represents 40 percent of all U.S. manufacturing profits for last year, up from 18 percent in 1978. The increase in oil profits has come at the expense of other sectors. Profits in other American industries declined in 1980 due to the recession.

President Carter's gradual decontrol of oil added about $5 billion to oil company profits in 1980, and President Reagan's decontrol order will further swell Big Oil's coffers by at least $3 billion. Even decreasing demand, large oil stockpiles and the Windfall Profits Tax could not prevent the oil companies from raking in record profits once again.

TOP 20 OIL COMPANY PROFITS

[In billions]

Year	Actual	1980
1980	$29.2	$29.2
1979	22.5	24.5
1978	13.3	15.4
1977	12.0	14.9
1976	11.5	15.1
1975	9.6	13.6
1974	12.6	19.6
1973	8.6	15.1
1972	5.7	10.2

OIL COMPANY PROFITS, YEAREND, 1980

Company [1]	1980 yearend— Profit (millions)	1980 yearend— Return on equity (percent)	Percent increase in profit from 1979
Exxon	$5,660.0	23.4	32.0
Mobil	3,278.0	27.2	63.0
Texaco	2,642.5	22.4	50.0
Socal	2,400.0	23.8	35.0
Amoco	1,915.0	23.1	27.0
Gulf	1,410.0	15.3	6.4
Shell	1,542.0	20.5	37.0
ARCO	1,650.0	24.7	42.0
Phillips	1,070.0	23.1	20.0
Conoco	1,030.0	24.7	26.0
Sun	722.8	17.7	3.0
Sohio	1,811.0	49.1	53.0
Getty	871.9	23.4	44.0
Union	647.0	20.3	29.0
Citgo	477.5	19.8	27.0
Marathon	379.0	20.9	17.0
Ashland	196.5	19.1	5.4
Total (or average)	27,703.2	23.2	35.0

[1] In order of net worth.

Mr. **LaFaver**. Frankly, the proposals in Washington that alarm me the most are not yet a part of the congressional budget process. They do not address substantive specific issues of health care. They involve funding formulas, and their impact, if enacted, would be many times more severe than the budget proposals of the President or any of the proposals that are now in the final stages of congressional debate.

Under present law, Montana pays 35 percent of medicaid costs. We pay 40 percent of the cost of aid to families with dependent children, the major welfare program. Under proposals that are being debated in the Senate Governmental Affairs and Governmental Relations Subcommittee, Montana's participation rate would increase for these programs to as high as 60 percent. The purpose, apparently, is basically to have the States which levy severance taxes pay a much larger burden than they presently pay. I do not intend to debate the merits of those proposals here. I do want to emphasize the devastating impact such proposals would have on health care for needy citizens in Montana. The annual cost of the proposal would be $19 million. Presently, medicaid costs Montana $28 million annually. AFDC costs another $5 million, so the total cost of both of these programs is $33 million per year. Adding $19 million of costs to a $33 million program would constitute a 58-percent increase in one year. It would buy no added services for Montanans. It would be a gift of the Montana people to the Federal Government. From 1980 to 1981, total Montana State general fund revenues increased 25 million. Taking $19 million of this amount would be using three-fourths of our new State revenues to simply stand still. It would leave only $6 million for inflationary adjustments on a $260 million State budget.

Obviously, such extreme proposals would wreak havoc with our medicaid program and with our State budget generally, and I urge you to proceed with extreme caution on these proposals.

That concludes my remarks, and I appreciate the privilege and the opportunity of being with you this morning.

Senator **Baucus**. Thank you very much, John. I'm sure Senator Durenberger has some comments on the remarks you just made. I know we all focus in on that point very, very closely because of our State.

I would like to ask the Governor, and perhaps you, too, John, a question. How much savings do you think the State would realize, primarily in medicaid—medicare, too—if a lot of the Federal regulations were cut back or eliminated? I know under medicaid, the administration wants to basically half medicaid funding, and some of the States say that they could realize a lot of their savings if a lot of Federal regulations were cut back, and I'm wondering if you could tell us the degree to which savings could be realized to cut back in Federal regulations; and, second, the degree to which savings can be realized with more State flexibility, or more State autonomy on how these dollars are allocated.

Governor **Schwinden**. Let me try to respond first in a broad sense, Senator, and I'll ask both of the directors to respond in terms of their agencies.

Two points; one is that Mr. LaFaver and the Department of SRS, under his direction, have just undergone probably the most major organizational shakeup that I've seen in some 20 years of observing State government, and in the reorganization process, some 40 high-level, relatively high-level, administration positions were eliminated in order to translate or transfer more dollars out of the programs to clients of that agency. And the savings, while it was significant, $1.3 million, compared to the total overall cost of medicaid, AFDC, and so forth, is obviously very small.

The other point that I would make is that our legislature has made it clear that if the determination of the Congress and the administration is to move significantly toward the block grant process in particular, they want to create a section of actual writing that into the appropriation measure, saying that if it's simply a matter of dollars, they'll let the executive stew for a while. But if it comes down to a decision in terms of changing the priorities of use under a block grant, that the legislature wants to make that decision. And so, you know, in terms of total regulations, I suppose if we move to block grants, we're looking at a whole new ball game in which our own legislature is going to play a significant role.

John?

Mr. **LaFaver**. Yes; the original proposal that we were reacting to, the President's proposal, in medicaid alone would have cost us $10 million over a 2-year timespan. I didn't see any proposals in terms of flexibility of programing and all that would have made up anything like that amount. But especially the action in the Senate which has served to raise that cap to a 9-percent increase will cost us considerably less. Also, the House proposal to lower the Federal participation rate by 2 percent generally would also leave us much better off than the President's proposal. Under either of those circumstances, if we are given the authority to control hospital costs specifically, in a much broader sense and in a way that has a lot more teeth than it has now, I suspect that we can provide the same level of services that we are now providing with no dramatic impact on the program.

Senator **Baucus**. Let me ask the question a little differently. In your experience—let's take both medicaid and medicare, which is funded much differently—but in your experience, can a significant number of dollars, Federal dollars, be saved through cutbacks or elimination of some of the Federal regulations, some of the paperwork that the State has to administer in medicaid or the hospitals do in medicare? I'm just curious as to how much savings can be realized in cutbacks and regulations that really don't help provide better health care to people.

Mr. **LaFaver**. Well, there is no debate but that to the extent that those regulations can be reduced and streamlined, there will be considerable savings. It's very hard at this point to look at a specific proposal and put a $2 million price tag on it, but to the extent if cutbacks occur, both in the medicaid program title XX, and if the regulations are reduced, and if the States are given greater authority to spend those dollars in a way that is responsive to State needs, we can overcome a lot of the adverse impacts that we would otherwise have. So, of course, I have encouraged you, and I have encouraged others, to try to pass on this lower amount of money in as much of a block grant as is possible.

Senator BAUCUS. You made a very good point, I think, Governor, when you pointed out that a lot of these allocation formulas have a space factor, because of all the problems that Dr. Drynan mentioned with food and lodging costs, and distance problems of time, distance problems of transportation costs, day care problems with kids, how are you going to leave the farm, all those problems that hit us more acutely in the sparsely populated areas as compared to more densely populated areas, I'm wondering if whether you had a chance or an opportunity to refine that a little bit; that is, how we can calculate the space factor as compared to a situation of dense ghetto problems. I suppose they have their own special kinds of problems in those parts of the country. Are you yet in a position to flush out a little more how to get guidance as to how to write into a bill some kind of space factor? Because I think it's obviously needed.

Governor SCHWINDEN. I don't know how to do that. I honestly don't know. I suppose you could look at maps like Dr. Drynan has produced in terms of a number of people in square miles and medical services that are presently available. As you and I both know, Max, there are a half a dozen stories each year about the way that rural people address the problem of one of the members having to go in for surgery. There's usually a story about how the neighbors pitch in to seed or to harvest, and so forth. Without that kind of community support, the cost will get staggering. It's almost impossible to have somebody come in on an overnight basis and take over an operation like that, the rural structure. I mean, I don't know how you develop a formula like that. I guess space is a factor. I guess you could look at miles traveled, physician density——

Senator BAUCUS. Yes; I was curious how you were going to try to develop that, because obviously many instances in the next weeks and next months and years, as the Federal Government is cutting back the number of dollars, it's more fierce battling how those dollars are allocated, and it's falling on us in the sparsely populated areas to make sure we're protecting ourselves and not getting short-ended on allocation.

I want to thank you very much for your testimony. Senator Durenberger has a couple of questions he wants to ask you.

Senator DURENBERGER. Let me just follow on in the track Max was on relative to what we're doing for you while we're taking your money away from you, and I've got to keep saying it's your money. It's not our money. We run the printing presses, but taxes come out of the folks' pockets, and I think what we're all about here is trying to find better ways to do things for less of an increase in funds.

But one of the things under medicaid, of course, that we are giving the States, theoretically, is freedom of choice. In other words, you can now, in the ideal setting, you can, where we're getting rid of this freedom of choice, we're saying that you now have the power to say, you know, "If you go to a more cost effective hospital, we pay the bill. If you go to a less cost effective hospital, you're going to have to share in the bill." Whatever arrangements you might put together. One of the problems I sense in the State of

Montana, though, is there isn't that much choice available, so it's really hard to use that as a tool.

Another tool that you're going to be able to use is prospective reimbursement. In other words, you can make arrangements, in effect, ahead of time with providers of service at what you think is a fair cost. They're going to negotiate those costs rather than just paying the bills at 80 percent of reasonable and customary. Something like that.

We're also giving you the authority to go into competitive bids on eyeglasses and a variety of things like that.

Given the degree to which we propose a cap, are we really giving you the tools with which you can do your job better for the dollars that are going to be provided?

Governor SCHWINDEN. OK, let me just make one comment, I guess, in terms of like the ability to go to the lowest cost hospital. I served for a period of time—Montana has a voluntary cost containment program. It is funded by the State hospitals, and I served on that board for a number of years and know, for example, that there's a very wide discrepancy that exists in terms of hospital costs. I can see all kinds of problems just in terms of where, as you've indicated, where you would go with those people. You would take someone from extreme eastern Montana, and if, for example, the lowest cost hospital were in Hamilton, a hospital, I suppose—I'm guessing—of probably 30 beds or 40 beds, you couldn't do it very often. The distance is staggering. So you have some real problems as opposed, for example, to the Minneapolis/St. Paul metropolitan area where, within that area, there are a number of very excellent facilities and you have, you know, a competitive situation, plus all kinds of opportunities, at least for the urban population.

John?

Dr. DRYNAN. There are going to be several problems with that. One of the things that you have to realize in Montana is that most of the hospitals are competitive, and they are priced much lower than most of the hospitals in the rest of this country, and it's a proven fact with the doctors in Montana with the fee schedule, the relative value fee schedule that's been set up, when you look at Montana, Wyoming, and North Dakota, they are the cheapest priced doctors in the country, so how do you go ahead with a competitive bidding process with doctors who are already collecting, in many cases, 100 percent less than their counterparts in California? They're already doing it for you, so I can't agree with the statement, "Go along and ask them to take more of a cut than they already are for the privilege of living in Montana."

Distance, like I say, is a real problem to get people from hospital to hospital, and if you do that, then you're looking at implementation in every county of airports with capabilities of fixed wing and helicopter, in addition to the ground ambulance transport system.

Senator DURENBERGER. But are there some economies to be achieved by the State determining exactly how it's going to reimburse hospitals? I mean, we've got some opportunity there, given what you say about Montana, which I certainly believe, particularly when you compare it with a city. Aren't there some economies that could be achieved by, particularly, the same prospective reimbursement as opposed to the other?

Dr. **DRYNAN**. John can answer that.

Mr. **LAFAVER**. Yes; I think clearly the answer is yes when you compare the increase in the nursing home costs in Montana to the increase in the hospital costs. Of course, we have, over the past couple of years, increasingly controlled the nursing home costs very well. Hospital costs have increased more rapidly, and at least partially the reason for that is because we do not, at present, have the same authority to control those costs as we do the others.

Governor **SCHWINDEN**. Just 1 second. I think Dr. Drynan has one comment.

Dr. **DRYNAN**. In addition, when you talk about hospital costs, you still have to pay the minimum wage as established by Congress, and that's what they're doing, but you have to compete also for nursing services.

One of the things that never gets addressed in this talk about hospital costs and the rising costs of medicine in this country is the producer or the product suppliers who are supplying their wares or their products to the hospital at markedly increased prices over what you buy them for the U.S. military, and yet we're buying in the same amount in proportion, and the same amount of materials is being bought. So in order to get hospital costs down, in addition, somewhere along the line, you have got to put a cap on industry, too, as far as what it costs for the hospital supplies.

Senator **DURENBERGER**. In the Twin Cities situation, you could almost suggest the marketplace could take care of that. When you come to Montana, it's pretty hard to get, the whole hospital association of the State to get together and try to bid competitively. You don't have the marketplace clout, and so you're suggesting you need some help someplace else?

Dr. **DRYNAN**. That's right.

Senator **DURENBERGER**. OK.

Governor **SCHWINDEN**. Let's work that into the formula, too. That's part of space.

Senator **BAUCUS**. I wonder, John, if you could follow up on that point just a little bit more. I asked the hospital administrators that same point often, and the answer I generally get is no, that's not a problem; that is, we don't pay any more for bed pans than you can get down at some other hardware store, for example, or hospital beds really don't cost that much more than it would cost to buy a comparable bed, you know, for a home, or something like that. Could you expound on that a little more, please?

Dr. **DRYNAN**. Well, I think that may be true; if I go buy the same bed for my house, I'm going to pay the same price, but I'm not buying a bed that has electric foot raisers or a bed raiser or head raiser and what-have-you. I think the cost would be the same to me in Montana if I bought it for my house.

Senator **BAUCUS**. But are you suggesting that—I'm sorry. Go ahead.

Dr. **DRYNAN**. However, the cost for other factions would be less. Let me give you an example.

I guess the best way I can put it is when I came to practice, we bought instruments, for example, a needle holder, a simple needle holder for surgery, at $150. I got the same needle holders from the U.S. Army for $15. Now that's quite a markup, and I don't understand, you know, if a private hospital has to pay this amount versus governmental hospitals, what's going on, and how can you bring hospital costs down unless you charge the same for both entities? And I'm sure it's on a base of how much they buy, maybe. I don't know.

Senator **Baucus**. It's a subject that intrigues me very much, and I don't know the answer to it, either.

Senator **Durenberger**. Max, why don't we address the long-term care issue. When we were originally dealing with the Governor's association on the cap issue, one of the propositions the Governors made to use was we don't want a cap because we're the ones who are out there finding the ways to hold down the costs, and if you artificially cap the amount of money coming in there, you're taking away the resources that we need to use as incentives. But they did say that a cap on long term care might facilitate some needed change in that system.

Now what I heard here, I think it was from you, John, sounds as though Montana is already able to do some cost saving things in long-term care, and if that's so, I'd either like to hear about them or some suggestion from you about what we ought to do to the medicaid and medicare system that would help you do the job of holding down costs in Montana.

Mr. **LaFaver**. Right. We can hold down the increases in terms of the operating costs of nursing homes, but as you know, we have very, very few options available other than the nursing homes, and there are other options available that would cost a good deal less, and I believe the proposal of the National Governors' Conference was to open that up so that States could choose either personal care facilities, or whatever, so that we could move people out of nursing homes and into a less costly environment.

Senator **Durenberger**. Is the home health care, in a State where there's widely disbursed population as Montana's, a major solution to deinstitutionalize alternatives?

Mr. **LaFaver**. We think it is, yes.

Senator **Durenberger**. Just one last question as a general one. We talked about, or John talked about, what the Intergovernmental Relations Subcommittee is up to, and one of the main things we're trying to work on is this notion of what's the Federal role and what's the State and local role in providing for the needs of people, and if there's anything we put a lot of attention into, it is the notion that the Governor, I am sure is familiar with, of sorting out functions and saying that perhaps the major national function or responsibility should be guaranteeing the economic access of people to their services so that you take things like AFDC, and perhaps medicaid out to be in some sense federalized, but elementary and secondary education and transportation, social services, these things ought to be defederalized and ought to be the responsibility of States. Now Bob Carlson, who has the ear of the President because he had the ear of the President when he was the Governor, says no to that sort of thing. The Federal Government needs the States, the leverage economies of welfare, and, in health care, therefore, we can't ever get out of this combination of the State and Federal Government and AFDC and medicaid, and it's an interesting—I'd be interested in hearing your reaction to that, including the question.

Governor **Schwinden**. Well, it's an excellent question. It was one that occupied most of the time at the late February Governors' Conference back in Washington, and that was my first visit there with the group.

It seemed clear to us from our discussions with the President and with Mr. Stockman that there definitely is a move toward not only the block grant system but also a withdrawal of Federal Government financing or responsibility in at least three areas: education, transportation, and law enforcement. The reaction of the Governors was relatively predictable. The overwhelming majority of Governors were very receptive to the idea that Mr. Stockman proposed of the Federal Government moving out of the transportation area, the highway transportation area, turning over the 4 cents to the State, but those of us who come from States where there's one hell of a lot of miles, 4 cents doesn't bring in much and is bringing in less every year.

I see some real problems, and yet I'm sure the urban people from the East who want to drive across Montana want to drive across excellent highway, and there was certainly even more of a consensus from some of the other areas. For the first time in the last couple of years, I've run into increasing school people who say that the complexity of the problems associated with the multiplicity of small categorical grants isn't worth the time and effort that goes into them, the people that you have to hire to prepare the grant applications. And so, you know, I just frankly, Senator, and I'm summarizing a very important topic, I really believe this is World War II. The States, in general, have come of age; that they are willing to accept an increasing role in the Federal-State partnership, and you're very familiar, of course, with the kinds of frustrations that were expressed in the Sagebrush Rebellion, and those go beyond just the issue of who is going to set the grazing allotments on the CMR Refuge. They are, I think, a very healthy reaffirmation of the States' 10th amendment rights. We have matured. We are prepared to take our place, and many problems can be better solved here than they can be solved back there. The sagebrush seems to get a lot dimmer when it gets back to Washington, at least in some of the early decisions of the Secretary of the Interior vis-a-vis offshore oil leasing and so forth, So, no, I think it's a good trend. Again, it's like formulas which are very difficult in terms of allocation of Federal money. The situation differs so greatly between States that, on the surface, appear quite similar.

Senator **Baucus**. That's a very good point. I mean if you take the country and divide it up in 50 equal segments with equal population density and equal resources and equal access to ports and the other transportation hub, maybe it would make some sense. But we are such a diverse country, and the States are different, but it is very, very difficult to draw a formula.

Well, thank you all very much, gentlemen. It is very helpful. We will now take a temporary recess no longer than 15 minutes.

[Recess.]

Senator **Baucus**. All right, folks. Let's begin the hearing.

Our next panel will include, according to the list of witnessess, Brad Schaefer, Montana Farmers Union, and Charles Banderob, Montana Senior Citizens Association, and Wade Wilkinson, executive director of the Low Income Senior Citizens Association.

I saw Charlie a little earlier. Why don't you come up here. If Brad Schaefer or Wade Wilkinson are here, either of them may come up to this panel, too.

[No response.]

Senator BAUCUS. OK, Charlie. I think you're the panel. I don't see anybody else coming. Why don't you go ahead.

STATEMENT OF CHARLES A. BANDEROB, PRESIDENT MONTANA SENIOR CITIZENS ASSOCIATION

Mr. BANDEROB. The problems and prospects of providing and receiving health services in rural Montana.

Mr. Chairman, members of the committee, ladies and gentlemen, for the record, I am Charles A. Banderob of Ballantine, Mont., a small rural town in southcentral Montana of about 500 people. I am president of the Montana Senior Citizens Association, a statewide organization of 8,500 senior citizens.

The MSCA has, for several years now, been asking for more home health care directed by local community groups, for more local health maintenance organizations, and more Public Health nurses working with local health comsumer organizations.

The State of Montana is 1,392 miles long and 1,169 miles wide and has 56 counties in it. See attachment A [exhibit 5]. This is a map. To provide proper and equitable health service to the people in all 56 counties requires considerable Federal help. It involves much more than just the medical aspects. Transportation, communications, energy needs, and minimum income needs all have a strong relativity to providing and receiving a halfway decent amount of health care services. Halfway decent is not good enough in the kind of a society and nation we profess to be.

The skimming of the cream off all of Montana's people's health needs and concentrating it into some seven or eight major centers, and by so doing, starving the rural county or community health centers and hospitals to death, is not providing the people and their communities with proper health services.

I know of an elderly woman who recently developed a severe case of indigestion in the middle of the night, lasting until 4 a.m. in the morning. Along with her heart condition, she needed a doctor's attention. She could not be moved or travel; it was that severe. The doctor was 25 miles away. It was a Sunday morning, and he was not available.

I know of a young mother of four who has digestive troubles, has paid doctors over $1,500 for treatment of it to date. She is of low income and does not have that kind of money, so she had to prevail on her 80-year-old stepfather to help. Now she is told she needs three X-rays on her stomach and that she has to come up with $75 before they will X-ray her. This is not providing or receiving adequate health care in rural Montana.

These kinds of situations are widespread throughout the State.

Montana'a rural areas need greater help for their community or county hospitals and health centers. We need more doctors and nurses in rural areas. The nurses need more authority. We need more paramedics. We need to develop and expand the midwife practice and licensed massage therapy. Above all, we need to develop more of nature's ways of sickness and ailment prevention and cures. The human system has much of it built in, but we need to understand it better.

The Montana Health Systems Agency has done a great deal toward directing a much improved balance of health services delivery by health providers to all areas of Montana, but all too often we're stymied by the few selfish and/or large providers. I have attached a resolution on the Montana Health Systems Agence as adopted by the Montana Senior Citizens Association members at their annual meeting last fall. See attachment B [exhibit 6].

No amount of recommendations for providing and receiving improved health services in rural Montana will be of lasting duration unless we, the great Nation we think we are, set up some stringent guidelines and take the Federal action ncecssary to curb inflation. Twenty to twenty-five percent interest will not do it, nor will the 25-cent postage stamp. They just fuel inflation.

No nation can long endure the extraction of $27.5 billion in net profits by a handful of energy conglomerates as they did in 1980. See attachment C [exhibit 7]. And I want to ad-lib a little here. To gather $1 billion together, you have to gather $278,300 an hour, every hour, day and night for a year to get $1 billion, and the oil conglomerates extracted right at $30 billion net above all costs out of our economy. No nation should stand still for the exploitation of its people by the greedy in the health delivery services.

These kinds of things, coupled with the other gross inequities, develop the seedbed of discontent that eventually destroys a society.

We are not insecure for lack of military might. We are insecure due to the gross inequities. Let us not be swooned to sleep.

We need a National Comprehensive Health for All Americans Act, not the MX missiles.

On behalf of the members of the Montana Senior Citizens Association, I want to thank Senator Baucus and the other members of the Senate Subcommittee on Finance for this opportunity to appear before you and present this testimony.

Thank you. Charles A. Banderob, president of the Montana Senior Citizens Association.

Tom Ryan of Helena, Mont., would liked to have been here to also testify on behalf of the Montana Seniors, but due to earlier family commitments, was not able to do so.

Thank you, Mr. Chairman.

Senator BAUCUS. Thank you very much, Charlie. I want to thank you for coming. In the years that I've known you, I think you have been one of the most persistent and helpful and effective advocates of the senior citizen's issues. I can remember about—it was about 8 years ago when we sat down and worked out a bill to enable Americans and Montanans in particular to dispose of their property by joint tenancy to in some way avoid some of the unnecessary high probate costs. And since that time, too, you have helped organize the Montana Senior Citizens Association. And to instruct me through the years, you have been one of the few people who have hung in there and continued to stand up for and work for the solution of the problems that face the senior citizens as well as some other Montanans who are in a less privileged position, and I want to thank you for those efforts.

Mr. BANDEROB. Thank you, Senator. There are very few hanging in, and we're going to get more of them.

Senator BAUCUS. Let me ask you a question. In your opinion, the degree to which the medical community is trying to solve the rural health care problem, are the physicians trying to figure out some way to help enable or entice and encourage physicians to practice in rural areas, or are hospitals trying to, with some outreach services, through cooperation and establishment of home health care services, trying to be helpful, or are they not? I'm just trying to find out whether, if they're trying, are there impediments elsewhere, or are they not trying hard enough in your view?

Mr. BANDEROB. As many of us that have been in this game over the many years realize, there has to be some additional financial assistance to the rank and file people in their efforts to bring about corrections of the gross inequities, not only in the medical field but in the balance of the economic field, but it does have a real bearing on the medical and health aspects. The local people voting in communities, counties, and States can develop a lot of corrective activities, but they need the financial assistance of the Federal level because our economic system extracts out of the masses of the people such excess amounts of nets that there is no adequate financial resources available in the local communities, and, therefore, we need a balance between Federal financial help and local and community and State planning and direction of corrective activities.

Senator BAUCUS. I ask the question in part because the Federal resources are becoming more limited these days, and I'm wondering whether the private sector, physicians, hospitals, nurses, other members of the medical community, can provide better rural health care. Are they in a position to do so, or are they not inclined to do so? I mean, in addition to the Federal dollars, because there is increasingly a limitation on Federal dollars, where else can we find a solution?

Mr. BANDEROB. If we want to maintain a comparable level of wages for the working people in the medical profession, there is not sufficient resources, financial resource available, and given the local county or State communities to do the job, because there is concentration of this resource in the hands of a few, and it behooves the Federal agency and the Federal Government to help redistribute that buying power to the people who are in need.

Senator BAUCUS. So what you're saying is we do need the Federal assistance, either in direct dollars in rural health care areas, or some other kind of Federal legislation to encourage others to provide health care in rural areas?

Mr. BANDEROB. This is right. When we analyze the extraction of the excessive nets that are extracted by even the higher income agencies within the medical profession, and that coupled with all of the other major corporate conglomerates, the Nation does have the resources. It's a matter of direction.

Senator BAUCUS. Thank you, Charlie.

Any questions, Dave? Senator Durenberger may have a question.

Senator **Durenberger**. Just one question. Why do you say there should be more HMO's in Montana?

Mr. **Banderob**. The local people won't participate, but they need the Federal assistance financially.

Senator **Durenberger**. For HMO's?

Mr. **Banderob**. Yes; there has to be teamwork on this.

Senator **Durenberger**. OK.

Senator **Baucus**. Thanks, Charlie.

Mr. **Banderob**. You bet. Thank you.

Senator **Baucus**. OK. Our next witness is Dr. Johnson from the Montana Medical Association.

Thank you very much for coming, Dr. Johnson. The forum is yours.

STATEMENT OF DR. M. A. JOHNSON, PRESIDENT, MONTANA MEDICAL ASSOCIATION

Dr. **Johnson**. Senator Baucus, Senator Durenberger, and staff, I practice in a rural community in Montana, and so I think I have some expertise in this area.

[The prepared statement of Dr. Johnson follows:]

Prepared Statement of M. A. Johnson, M.D., President, Montana Medical Association

We like many States, have areas that are medically underserved. We have had some decrease in the number of rural family practitioners or general practitioners within the state. Several years ago, a member of the State Board of Medical Examiners determined that the average age of physicians in rural Eastern Montana was 56 years of age.

My thoughts as to how this problem can be best improved, revolve around a family practice residency being developed within the state. An attempt has been to do this in Billings, Missoula and Great Falls; however, the physicians of these communities have actively opposed this concept. I honestly believe that such a program could be developed in Billings or Great Falls. If a speciality type organization, such as the Mayo Clinic, can develop a department of family practice and a residency in these communities with primarily speciality practices have the potential for the same type of program. A residency program to respond to this problem would have to meet all the criteria set-up by the accrediting agencies and would need to offer some special elective training to enable these residents to practice in the rural communities without immediate speciality backup. This program could also have build into it a means to help the rural communities develop and maintain their medical services. Over the past several years, we have seen another phenomenon develop. Various rural communities have entered into arrangements with management organizations to provide medical care to their communities. Sometimes this is done with full-time physicians and other times it is done by a series of physicians a few weeks at a time. This has had a tendency to cause increased disruption of the existing medical community. This has also set up somewhat of a barrier that prevents other physicians from coming into a community to establish a private practice. This has been extremely expensive to the community or county who enters into this arrangement because of the relatively high salaries involved with no productivity requirement.

The rural hospital tends to be the hub around which medical care develops. These are generally small facilities with problems of financial solvency and are burdened with a great deal of regulation, much of which, is tied directly to the Medicare Program. In our hospital, we currently have more personnel in the business office than we have on the floor taking care of the patients. These hospitals now depend on medicare for about half of their income. When the non-medicare allowed charges are deducted, these facilities operate at a loss only to be recovered by adding these costs to the expenses of the private pay patients. This results in an unfair discrimination against the private pay patients as these are the same ones who indirectly pay for the medicare patient also.

Generally, the small rural hospital is able to provide basic care at a lesser cost than the larger metropolitan hospital. There is also a cost saving to the patient's family if they do not have to leave the area to visit the patient in the hospital. If there can be any changes in the regulations to facilitate the operation of these smaller hospitals it will not decrease the quality of care to the patient but may decrease the rate at which the cost of care increases.

The area of emergency medical services has improved greatly over the past six or seven years, as a result of federal involvement with funding. Most of our state is well covered with manpower and equipment. Again, there is a problem in some areas. Especially, if an area cannot support medical services they usually cannot maintain a personnel and equipment to have an ambulance service. This service would have great potential benefits for such an area. We've tried to work with a couple of such areas and I believe that we might have to accept this as a fact of life. In other areas there is still some need for training of personnel which is not being met by either state or federal funding.

A nationwide shortage of nurses has not missed Montana. In many rural hospitals this is a perpetual problem. We have had nursing programs closed down completely within the state and have recently heard discussion of cutting back the nursing program at Montana State University by cutting out the program at Butte.

We are faced with a shortage of nursing home beds in parts of the state. This has resulted in an increase in length of stay in the acute care hospitals. This in part, is related to the certificate of need legislation. The cost and effort to get through this process is just too great. Many small facilities have been through this process once and the volunteers on the various boards don't want to go through it again. The effect of inflation has also had some impact on this problem.

The role of the nurse practitioner and physician assistant should be addressed. Both should be considered as a physician extenders, not replacements. They are currently being used in Montana. In fact, I have a nurse practitioner in my own office and she works directly under my supervision and on such days, such as today, the physician in the adjoining office works closely with her. A major problem with utilization of the physician extender is what is direct supervision by a physician. The recent legislature passed enabling legislation for physician assistants to be certified to practice with a specific physician who is responsible for their actions. My experience with my nurse practitioner has been very favorable.

In many of the smaller communities that cannot support a physician it may well be that they cannot support a physician extender either. This has been experienced in other states. They might be able to support someone on a part-time basis; however, the expenses for space and equipment are in essance the same. Especially, with the current effective inflation it is economically impractical for a physician to maintain a second office.

Not every community in Montana can support medical services. Most residents of the rual area can reach medical care within one-half to three-quarters of an hour. They may have to travel a greater distance in miles but they do not have to curtail with the traffic problem of the urban areas to get their medical care.

I have made an observation during my twelve years of private practice and that is, that most patients in Montana have little regard to distance and often pass through a community with a physician to obtain medical care when and where they want it.

Thank you.

Dr. JOHNSON. I am currently president of the Montana Medical Association and past president of the Montana Academy of Family Physicians and one of the directors for the Montana Foundation for Medical Care.

Senator BAUCUS. Two points here. First, pull the microphone a little closer to you and speak up so the people in the back can hear. Second, if you could tell us, for the record, where you practice in Montana.

Dr. JOHNSON. I practice in Choteau.

Basic health care in rural Montana is at a fairly high level and, in some areas, has actually improved over the last several years. These observations I made while a director for the Montana Foundation for Medical Care.

We, like many States, have areas that are medically underserved. We have had some decrease in the number of rural family physicians or general practitioners within the State. Several years ago, a member of the State board of medical examiners determined that the average age of physicians in rural eastern Montana was 56 years of age.

My thoughts as to how this problem can be best improved resolve around a family practice residency being developed within the State. An attempt has been to do this in Billings, Missoula, and Great Falls. However, the physicians of these communities have actively opposed this concept. I honestly believe that such a program should and could be developed in Billings or Great Falls. If a specialty type organization such as the Mayo Clinic can develop a department of family practice and a residency in these communities with primarily specialty practices have the potential for the same type of program. A residency program to respond to this problem would have to meet all the criteria set up by the accrediting agencies and would need to offer some special elective training to enable these residents to practice in the rural Montana communities without immediate specialty backup. This program could also have built into it a means to help the rural communities develop and maintain their medical services.

The WAMI program has offered a source of education for our Montana students, however these students must go elsewhere for residency programs and often thus end up locating elsewhere.

Another phenomenon developed over the last several years. This is the phenomenon of the, quote, "rent-a-doctor" service.

Senator DURENBERGER. I'm sorry; I didn't hear that.

Dr. JOHNSON. The "rent-a-doctor" service. Sometimes this is done with full-time physicians in the community, and other times it is done by a series of part-time physicians. They come in for a week or two at a time. This has had a tendency to cause, in some communities, increased disruption of the existing medical community. This has also set up somewhat of a barrier that prevents other physicians from coming into a community to establish a private practice. This has turned out to be extremely expensive to the community or county who enters into this arrangement because of the relatively high salaries involved with very little productivity requirement.

The rural hospital tends to be the hub around which medical care develops. These are generally small facilities with problems of financial solvency and are burdened with a great deal of regulation, much of which is tied directly to the medicare program. In our hospital, we currently have more people in the business office than we have on the floor taking care of the patients.

The other problems that we seem to face is the nonmedicare allowed charges. This causes the facility to actually operate at a deficit, and this deficit is, in turn, tacked onto the private pay patients' bills and continually escalates the cost of medical care.

I am going to skip over some of the other testimony that is printed [exhibit 8].

The emergency medical services area has showed great improvement with the Federal program over the last 6 or 7 years. However, we do have some areas that are presently still in need, and hopefully there will be a means by which we can bring them up to the standards that has occurred throughout the rest of the State.

Again, this is primarily in the rural areas and south, southern and eastern Montana.

The talk about regulation, my most recent run in with regulation was last Tuesday, the 23d of June. I had seen a medicaid patient who desired sterilization on February 23. She signed a sterilization permit that day. She underwent an electric sterilization on April 3, in excess of the 30-day waiting period. Medicaid was billed on April 14. On April 23, medicaid called and said they would not pay the bill because it was the improper Government form used for the consent. This was the previous regulation, the 72-hour waiting form, that was signed and not the 30-day waiting form, so this will not be paid.

In my practice, I generally treat all patients the same. I treat medicare and medicaid and private pay patients as if they were anybody else. In fact, I usually don't know who is what, and this is also a problem with our rural hospitals because they don't get paid for that hospitalization, either, because the form was improper, and they have no choice but to accept the medicaid patient.

The medicare regulation requires some problems, and the biggest one we have seen right now for physicians is that the particular requirement requires that the physician bill for only the service he personally renders. This morning, I left home before 4 o'clock in the morning, and Dr. Schwedhelm will make rounds for me. Well, if we followed the Government regulation, he would have to submit a separate bill on the patients that he saw for me rather than do it as a courtesy thing back and forth, which we've always done on all the patients for years.

This has caused a considerable problem around not only in Montana, in rural Montana, but throughout the Nation, and this was even brought up at the AMA meeting earlier this month.

The nationwide shortage of nurses has not missed Montana. The rural hospitals are plagued with this problem and we have had nursing programs close downs within the State and have recently heard discussion of cutting back the nursing program at Montana State University by cutting out the program at Butte. We are also faced with a shortage of nursing home beds in many parts of the State, especially ours. This is a result of increasing length of stay in acute hospital care beds. This is in part related to certificate of need legislation. The cost and effort of going through this process is just too great and the small facilities have already been through this process in the past, and the volunteers on the board just don't want to go through it again. The effect of inflation has also had some impact on this problem.

The role of nurse practitioner/physician assistant should be addressed. Both should be considered as physician extenders and not replacement. They are currently being used in Montana. In fact, I have a nurse practitioner in my own office, and she works directly under my supervision or on the days such as today, the physician in the adjoining office supervises her work.

The major problem with utilization of the physician extender is with the supervising physician. The recent legislature has now passed enabling legislation for the physician assistants to be certified to practice with a specific physician which is responsible for their action. My experience with nurse practitioners has been very favorable. In many of the smaller communities where they cannot support a physician, it may well be that they cannot support a physician extender, either. This has been experienced in many States. They might be able to support somebody on a part-time basis. However, the expenses for space and equipment are, in essence, the same for a part-time or full-time office. Especially with the current rate of inflation, it is economically impractical for a physician to maintain a second office.

Not every community in Montana can support medical services. Most residents in rural areas can reach medical care when they have to in three-quarters of an hour. They may have to travel a greater distance than the people in the urban areas do, but they don't have to contend with the traffic problems for the most part.

I have made an observation during my 12 years of private practice, and that is that most patients in Montana have little regard to distance and often pass through a community with a physician to obtain medical care when and where they want it.

Thank you.

Senator BAUCUS. Thank you, Doctor. Several thoughts came to mind as I was listening to your testimony. First is that as I'm sure you know, we in the Congress have recently, last year, passed a provision which will allow more flexibility in hospitals' use, or in trying to meet medicare standards. The smaller hospitals would have much more flexibility, and the general regulations applied to hospitals generally would not be as stringent with respect to smaller hospitals. Those hospitals, the smaller ones, haven't had a chance to utilize that.

Dr. JOHNSON. Yeah. They haven't seen it yet.

Senator BAUCUS. They haven't seen it yet, that's right. The regulations aren't out yet, and the same applies to the swing bed concept which will help hospitals in rural communities with some of the same regulatory problems. I'm wondering if you could comment on whether you think that's going to be helpful. It's hard to tell, because you don't know what the Government regulations are yet, but is that a significant step in the right direction?

Dr. JOHNSON. I think so. We've been talking the swing bed concept for 4 or 5 years now, and our particular hospital has the nursing home adjoining, you know, in actually all one building with an artificial barrier between the two. The nursing home is filled 100 percent of the time. The hospital occupany runs 50, 60, 70 percent, you know, up and down, but there are usually two or three beds in the hospital that could be used in this swing bed concept that would alleviate that problem within the hospital. Not too long ago, we had six patients in the hospital waiting for nursing home beds, and it does really cause a problem.

Senator BAUCUS. Well, we'll look at those regulations very closely to make sure that they accomplish the purpose that we intend in the legislation.

You mentioned that hospitals lose money on medicare patients. Could you elaborate a little more fully on what that problem is?

Dr. JOHNSON. Well, many of the charges which ordinarily are doing business charges are not allowed as medicare expenditures. Say if the hospital doesn't get paid and they have to borrow money from the bank to meet payroll, the interest on that money is not a legitimate medicare deduction, and so it's deducted. This amounts—now I don't have the current figures, but approximately a year ago it was a $25-a-day deduct from the actual cost. This added a charge to the private pay patient of almost the same amount, because we're dealing with 50-percent ratio of patients. And so this really does cause an escalating, you know, effect on health care costs.

Senator BAUCUS. We don't have the time to get into it here. If you have the time, Doctor, you might talk to the staff here. A person on our staff, with the Finance Committee staff, just mentioned to me that he thinks that that's a problem that the two of you can work out, but afterward, after you're through testifying, you might talk to him and see if you can straighten that particular problem out.

Another point that you mentioned is that you have had good experience with a nurse practitioner in your office. I find some resistance among the Montana physicians to nurse practitioners and physician extenders. What's the problem here? It just seems to me that there is a place, a role for nurse practitioners as physician extenders, and I wonder if you could provide a little guidance as to how and why that works in your case and why some other physicians might learn from your experience, if that's the case.

Dr. JOHNSON. I think that actually some physicians are maybe threatened by them. Many of them have had little experience as far as training with them, et cetera, and are just naturally uncomfortable with the concept. And I think this is where a fair part of the problem lies. I happened to get involved in this strictly by accident. I kind of had my arm twisted by this nurse practitioner who needed a preceptor, and so, like I said, I had my arm pretty well twisted and I didn't know any way out, and so I said yes, and she's worked with me ever since. But I think this is an individual problem; the personalities of the individuals, you know. Some people can get along with a certain type of person better than somebody else, and if you have a combination where the personalities work well together and are comfortable together, I think it works very well, and she works primarily right in the office with me where, you know, there's no real direct supervision problem. She does see occasional patients who come to her house at night or something, and she will either follow her program to use or call me.

Senator BAUCUS. Do you think that the utilization of nurse practitioners and physician extenders will significantly help solve some of the medical care shortages in rural areas, or is that just going to be a small contribution?

Dr. JOHNSON. I don't know. I don't think it's going to be significant.

Senator BAUCUS. Why is that?

Dr. JOHNSON. It's just that you still have to have a physician supervisor. Adequate supervision, I think, is really the problem there.

Senator BAUCUS. As a practical matter, how many miles away can the supervisor be?

Dr. JOHNSON. This is the thing that we really don't know. I know no qualms about the gal who works for me. I know what she does, and I know when she has any problem that she's going to call me. I have this confidence, and we have developed this relationship. But, you know, everybody's situation is a little bit different, and I don't think that you can do this over a great distance. I think you have to have a fair amount of close supervision and working together where I can see that my gal could go out for—say we're talking about in a neighboring community providing, say, medical services 1 day a week. She would come back in, and I would see her at noon, and we would go over what had transpired. But I think that they're not going to be a free-standing thing. I don't think that this is the means by which these people should be used.

Senator BAUCUS. Thank you very much.

Senator DURENBERGER. Let me direct my question which deals with HMO's to basic definitions, which I should have given Charlie before I asked him the question about Montana, and I'm asking because I don't know.

I distinguish the HMO from the fee-for-service system with a couple of basic definitions. It's a limited group of providers who render service for an agreed amount advance fee. The most common example of HMO's in rural areas would be the individual practice association. I don't want to get into the whole issue of federally qualified HMO's, but you probably know Bob Kelly from Grand Rapids who is active in the American Medical Association, and Bob, you know, can see all of the problems with the Federal Government mandating things, but he's also addressed through his own IPA some of the problems of rural health care in northern Minnesota, and he's not done it through a rent-a-doctor program or any of that short of thing, but just arranging, as part of the membership in his IPA, for a doctor or doctors to be at least 1, sometimes 2 days a week in some of the small communities stretching over a couple of hundred miles. Everybody in town knows the doctor will be there, that the doctor is part of a larger group centrally located, in this case, in Grand Rapids; 12,000, 15,000 people, something like that. And when Max tells me competition doesn't always work in rural areas, I use this as an example of where a different kind of a system than fee-for-service can work for rural areas, and I'm curious to know whether the whole concept of HMO's has been tried in Montana, if it runs up against some of the problems you talked to in terms of the family practice residency program and the nurse practitioners, and how could you go about resolving it in a State like this?

Dr. JOHNSON. The current thought is we've had people present to the medical association the concept, and so far it's not gathered any momentum whatsoever within the State. The problem is the vast area that we are covering, and in order to do much with that, I don't think we have one population base, and then the geographic area is so scattered, that it just seems totally impractical. There have been periodic thoughts on this, and we've had people from various parts of the country come in and present their idea of, you know, how theirs is working and what's happening there, but it doesn't look like it's going to really work. There have been some scattered attempts to organize it a little bit and, say, in one little given area, but it doesn't look like it's ever going to come about just because of the diffuse problems involved.

Senator **Durenberger**. Has it been tried at all in Billings?

Dr. **Johnson**. No, not that I'm aware of.

Senator **Durenberger**. Let me ask you one last question that deals with—and this has come up several times today—the issue of education, medical education. My impression is that medical education for Montanans comes out of consortium with the Washington State base.

Dr. **Johnson**. [Witness nodded head affirmatively.]

Senator **Durenberger**. And I'm very sensitive to what I have heard here today about the need for Montana educational institutions to carve out some piece of at least continuing medical education, and I'm wondering whether that's the responsibility that Max and I have as Senators, or it's the responsibility that Ted Schwinden has as Governor, or what seems to be standing in the way of advancing the cause for medical education in this area?

Dr. **Johnson**. This has been an interesting thing to deal with. I've been personally involved with it when the original concept came up here in Billings, and then groups of physicians were able to block the concept. Subsequently, an attempt was make in Missoula, and they felt they had too many doctors there the way it was. Missoula would not be geographically the ideal area for this program because where we want and need physicials is a long ways from Missoula. I think Billings would be your most ideal setting; Great Falls, next best.

Then we started about 2½ years ago in Billings, in Great Falls, going through the community, and then there is an Old West Trail Commission grant to the WAMI program to do a feasibility study for the residency, and this was undertaken in Great Falls. The physicians on one particular hospital staff just absolutely boycotted, just tooth and nail. It was conceivable that you could have pushed the issue and maybe tried to bulldoze your way in and set up a program in one hospital and not the other, which may have gone and may not have gone, but it would have created a bigger risk within the medical community then there already does exist the way it is, and it just went downhill.

Senator **Durenberger**. Thank you.

Senator **Baucus**. Thank you very much, Doctor.

One very quick question, and that's PSRO's. Should we keep it?

Dr. **Johnson**. Our State has been very successful; I think the PSRO has been very effective, and initially I was very upset with the whole concept. Having been involved with it now, and more involved, I am very much in favor of it. The medical association has been very receptive of this process, too.

Senator **Baucus**. Thank you very much, Doctor. You've been very helpful.

Out next witness is JoAnne Dodd of the Montana Nurses Association. JoAnne?

JoAnne, thanks for coming.

STATEMENT OF JO ANNE DODD, VICE PRESIDENT FOR NURSING, BILLINGS DEACONESS HOSPITAL

Ms. **Dodd**. Thank you.

Senator **Baucus**. I appreciate your giving the time.

Ms. Dodd. Senator Baucus, members of the committee, I'm JoAnne Dodd, vice president for nursing at Billings Deaconess Hosptial, and I'm here today as the immediate past president of the Montana Nurses Association.

I would like to address the first part of my remarks to not only the nurse shortage, but also the critical need for quality nursing care in the rural areas.

Is the nursing shortage that is being experienced by some of our rural hospitals in Montana genuinely from lack of persons educated to be RN's, or it it from a lack of willingness of those educated as RN's to work under the current conditions imposed upon on them? Some of the reasons cited by RN's for their unwillingnes to work in their chosen profession are the following.

One, misutilization of nursing personnel. This misutilization is reflected both in the assignment of nursing responsibilities without consideration to the level of preparation and the skills of the nurse and in the delegation of nonnursing duties to nursing personnel. This problem is compounded in the small, rural hospital where the RN is expected to be able to perform efficiently in all areas of health care plus take care of all the miscellaneous tasks. Often the rural RN works in an area with one only physician; and there are times when an emergency arises that that physician is not available, so the RN bears the total responsibility for the patient's care. It is vital that a well-educated RN be present in these small rural hosptials 24 hours a day to insure that quality patient care is rendered to the rural citizens on Montana.

And two, conditions of employment. RN's have identified salary levels, poor benefits, and unrealistic workloads as obstacles in the improvement of nursing care. Nurses become frustrated when they compare their workloads and compensation with those of other workers with less responsibility who are paid higher salaries and work regular hours. Rural nurses are asked to assume a greater responsibility, are often on call 24 hours a day, and yet they often have no input into hospital policies which help determine the standards of quality patient care. Rural public health nurses find their salaries and working conditions determined by county commissioners who are often more concerned with building and maintaining road and bridges than quality health care. Feeling frustrated because they have no input into the system and because they do not feel they are rendering high quality patient care, they leave their chosen profession.

Increasingly, unmet demands for nursing services signal an acute nursing shortage, as evidenced by the number of nursing vacancies in hosptials around the country. Our small rural areas have hosptials with minimal nursing staff who have difficulties providing the nursing care needed by the patient and perhaps one public health nurse assigned to take care of a population which is scattered over a great distance and has a large variety of health care needs. The problem is further compounded by an inadequate supply of registered nurses educated at the appropriate levels and by the growing unwillingness of nurses to work under adverse conditions. Working conditions have to be improved so that nurses want to remain active in their profession and to make others want to enter the profession.

Nursing educational programs are experiencing a decline in enrollment. We are confident that if the proposed Federal cuts in grants and loans to students in nursing programs is passed through Congress that the schools will experience a further decline in enrollment. State and community support for the nursing programs is also needed. This month the Montana Nurses Association received approval from the Department of HHR on a grant application requesting funds to study the nursing manpower needs in the State for the next 10 years. However, the grant application is not funded, and there are serious doubts that the moneys will be available to fund it. This information is desperately needed to determine where our nurses are located, where they are needed, and to assess the future needs of the citizens located in all areas of Montana. The Montana State University School of Nursing has experimented with a roving RN program to take their nursing program to rural students. Information on needs in the State is required so that the nursing programs can be placed in those communities which need them and to convince the State legislature to fund nursing programs in these areas.

In Montana there are aproximately 10 counties which are medically underserved. The MNA believes that these communities could be helped with their health care needs by the use of nurse practitioners working in collaboration with a physician. I was really interested in the comments that Dr. Johnson was making and the questions that you were asking him. The nurse practitioner is a primary care provider prepared to give continuous, personal care to the patient/client when that person enters the health care system and to continue as the individual's care provider. Studies indicate that more than 70 percent of the health problems in rural America are chronic health problems that limit activity and require continuous health supervision. Nurse practitioners possess the appropriate combination of physical and psychosocial skills to meet the needs of these people.

In 1977 Congress passed the Rural Health Clinic Services Act to provide financial support for facilities using physician extenders to promote primary health care services in rural, medically underserved areas. Several nurse practitioners attempted to open certified rural health clinics in medically underserved areas of Montana. Yet Montana still has no certified rural health clinics. Some of the problems experienced by the nurse practitioners were refusal of the State health department to certify any rural clinics because the State Nurse Practice Act did not specifically name them; medicaid reimbursement would not recognize the nurse practitioner in Montana; resistance from some physicians around the State; and excessive paperwork required by Federal regulations. Montana has a need for these clinics. Many of our communities are too small to support a full-time clinic or physician. However, a nurse practitioner in collaboration with a physician could adequately serve these communities through clinics open 2 or 3 days a week. Some studies estimate that a physician working with a nurse practitioner can increase the number of clients seen by as much as 40 percent.

The newly revised Nurse Practice Act now identifies the nurse practitioner as a specialty area of nursing. We have been assured that this change in law will make the nurse practitioner eligible for direct reimbursement from medicare and medicaid for services performed in a certified rural health clinic. We have also been told that changes to the rules and regulations are being considered to help alleviate the excessive amount of paperwork required for a rural health clinic. We hope that these changes will encourage health care teams to operate certified rural health clinics in the medically underserved areas of our State.

Thank you for the opportunity to appear before you today.

Senator BAUCUS. Thank you, JoAnne.

Regarding our conservation with Dr. Johnson, could you elaborate a little more on how nurse practitioners and physicians could get together a little better so that nurse practitioners can be utilized more effectively? How do we meet the physician's resistance, if we're agreed that it's there, to nurse practitioners? And you might also talk about the supervision problem.

Ms. DODD. I think that first of all we have to establish that nurses are not wanting to practice medicine, and that seems to be one of the big hangups that we have.

Senator BAUCUS. I think that's right. That's right.

Ms. DODD. I think nurses want to practice nursing, and there are a number of areas of independent practice that nurses can perform. It's my belief, and I believe of the association, that nurse practitioners should be supervised, that they can function under protocol established with the physician in collaboration with the physician. As long as they are meeting the criteria established by the protocol, they can then implement certain acts of practice. In the event that they are confronted with a situation that is not covered by those protocols, then they need to be in immediate contact with the physician.

In terms of your previous question about the distance involved, I can't answer that any better than Dr. Johnson can. It depends a whole lot on the nurse practitioners and the physician and the trust relationship that they have established with each other, and, again, there needs to be some kind of supervision, and I can't tell you what I think would be the appropriate distance.

Senator BAUCUS. By "protocol," what do you mean? Do you mean an agreement rendered wherein the doctor and nurse agree——

Ms. DODD. Yes.

Senator BAUCUS [continuing]. What decisions the nurse can make without consulting the doctor?

Ms. DODD. That's correct. A patient presents with certain symptoms, and as long as these are the symptoms that the patient has, then these are the things that the nurse does, and following that, then there are certain things that she can implement in terms of that patient's care.

Senator BAUCUS. And are you saying that even though protocol is agreed to, the physician, the question that we have to address, may intercede——

Ms. DODD. That's correct.

Senator BAUCUS [continuing]. Anytime——

Ms. DODD. Yes.

Senator BAUCUS [continuing]. And still exercise ordinary supervisory functions?

Ms. DODD. That's correct.

Senator **Baucus**. Could you help me with another problem? A couple of days ago in Bozeman, I talked with some nurses, and one nurse did a study of burnout syndrome and stress syndrome in eastern Montana; that is, in rural areas. I wondered if you're generally familiar with the phenomenon, and, if you are, if you may just describe the greater stresses and incidents of burnout of nurses in rural areas compared with urban areas.

Ms. **Dodd**. I certainly am familiar because I probably read much of the same literature as you do as it relates to burnout in nurses. They attribute it to overwork, overstress, the lack of trained personnel to work with them, the inability to practice professional nursing as they've been taught to because of the shortages, the inability to address patient care needs as they've been taught to do, and because they so frequently are, what they perceive as being, unable to give adequate care, they just simply leave the profession.

I personally don't believe in burnout.I think that's the in thing right now. I think that nurses do get overworked, are overstressed. I'm not sure what the answer to that is, but there certainly is a lot of emphasis on that.

Senator **Baucus**. But you think they're significantly overstressed as compared with nurses in other cities, say Billings, Great Falls, Missoula, or are they just as stressed?

Ms. **Dodd**. I think they're just as stressed in Billings and Missoula as they are in rural areas; yes.

Senator **Baucus**. Will the communities or the State be in a position to take up some of the slack where Federal funds are cut back with nursing education? Do you think that that slack will be taken up by States and communities?

Ms. **Dodd**. If that happens, then I think that hospitals and agencies as appointers will probably get to the point where they are paying scholarships for people to go into nursing and, in return, that person will come back to the agency and give them *x* number of years of employment in return for that.

Senator **Baucus**. The State agencies will do that, you think?

Ms. **Dodd**. I don't expect the State agencies would do that. I think that private employers will.

Senator **Baucus**. Private employers will provide scholarships with the understanding that the nurse then work for that private organization?

Ms. **Dodd**. Right. I note that some small hospitals are doing that. Some of the larger hospitals in Montana are doing that, also. We're doing that at Billings Deaconess, but please don't forget that the money that we use to support those nurses, those people to go through nursing, comes from our patients.

Senator **Baucus**. What experience do you have with medicare or medicaid redtape? Is that a problem, particularly as it affects small hospitals? Dr. Johnson talked about some of the regulatory problems that they face and situations where they don't get reimbursed.

Ms. **Dodd**. It's a problem for all hospitals in that we don't get reimbursed for our charges for patients, and so the private pay patient ends up paying more.

Senator **Baucus**. Is it a greater problem for smaller hospitals, as far as you know?

Ms. Dodd. I guess I'd rather defer that question to Bill Leary, who is going to be here before you shortly.

Senator Baucus. Thanks a lot. Dave.

Senator Durenberger. Whether you believe in burnout or not, I guess I do because I relate it to nurses in either a hospital setting or, as you've described it, a rural setting as opposed to working with a doctor in his office. I also see the same thing in public education, particularly at the secondary level, where teachers can't teach and nurses can't nurse because somebody else is telling them what they have to do, and it is either some kind of an economic or some other structure that gets built into some of these systems in our society so that people just can't do what they believe they were trained to do in the way of delivering service.

I think you have very well outlined the problems of improper utilization, workload and compensation compared to flight attendants. I think that one of the major problems in American health care today is the misuse of talented people who have not gone all the way to a medical degree; but whose sensitivity for the health care needy, particularly in the area of prevention, wellness, and the ability to diagnose problems, might have to be addressed by someone else. You are just the most underutilized profession in America today.

I am curious to know whether or not you agree generally with Dr. Drynan's analysis of the problems that related to the rural health clinic situation here in Montana, and I don't know whether I made notes of everything he said, but he said malpractice insurance is a problem, communications is a problem, the lack of instate teaching is a problem, transportation is a problem; then the definitions that we have put on "health provider" and we have put on "health facility," and I might have missed some other things, but were you here for his testimony?

Ms. Dodd. No, I was not.

Senator Durenberger. He said those are some of the problems that we have with the concept of the rural health clinic and the sponsoring physician and the relationships with a nurse practitioner. Would you agree generally that these are the problems?

Ms. Dodd. Yes.

Senator Durenberger. Thank you.

Ms. Dodd. I need to clarify when I said that I didn't believe in burnout. I must reiterate; I'm not saying that nurses aren't overworked and overstresssed. I think they do a tremendous job for the time that's available to do all the job they have to do.

Senator Durenberger. Yes. Thank you.

Senator Baucus. Thanks, JoAnne, very much.

All right. We have six more witnesses and 60 more minutes, so that works out to about 10 minutes apiece.

Next we'll hear from Sterling Hayward, who is with the Montana Foundation for Medical Care.

We are very happy to have you here, Sterling. I believe you are very active in this area, and we very much look forward to your testimony.

STATEMENT OF DR. STERLING HAYWARD, MEMBER, BOARD OF DIRECTORS, MONTANA FOUNDATION FOR MEDICAL CARE

Dr. **HAYWARD**. Thank you.

Senator Baucus, Senator Durenberger, and staff, thank you for the opportunity to testify before your subcommittee. I am Dr. Sterling Hayward, a member of the board of directors of the Montana Foundation for Medical Care and that organization's immediate past president. I am speaking for the foundation. Dr. Marc Johnson, you already heard from, and he is available for comments. Dr. Robert Whiting from Hardin, Mont. was supposed to be here to answer questions, but he was unable to attend. Both Drs. Johnson and Whiting are physicians who practice in rural areas.

If we combined the two hospitals in Billings or the two hospitals in Great Falls, those two communities would be considered urban in that their combined bed capacity would be well over 300 beds, according to the national guidelines. The same would be true in Missoula. However, no other city in the State with even combined hospital bed capacities exceeds 300 beds.

For purposes of presenting our thoughts on these issues, we have elected to include Billings, Missoula, Butte, Kalispell, Helena—Great Falls was left out. That might have been a Freudian slip, but, anyway—the Bozeman area and Havre, all communities which have a combined or individual hospitals which have over 500 discharges of Federal patients per quarter, as urban areas. We would like to further indicate that in our judgment, Billings, Great Falls, and Missoula certainly are communities that would be considered to be major referral areas for the rest of the State. Butte, Kalispell, Helena, and the Bozeman area have a broad spectrum of medical specialists and medical services available, although they do not have neurosurgery and open cardiac operative capability. The medical community of Havre is certainly growing rapidly and will soon be in the same classification as Bozeman, Helena, Kalispell, and Butte.

When we talk about geography, I think that has already been overdone, so I will skip that. One thing that we've always said is that if we put Alzada in Washington, D.C., Yaak would be north of Chicago, to give you a perspective.

As physicians, many of us elect to live in Montana because it is an area which is personally satisfying to us and, at the same time, provides the opportunity to work in a profession in which we feel we can best serve the public. Medical care has changed dramatically over the last half century. We frequently forget, however, that not just medical care has changed. Transportation problems are also vastly different today than they were 50 years ago and play an important role in our ability to provide quality health care.

A means must be found to make adequate medical care as readily available as possible. In those areas in which we cannot have onsite capabilities for a wide range of medical services, we must insure that adequate triage, coupled with a superb transportation system from outlying communities that is available to make such care as accessible as it can be, given the existing geography, population limitations, and facility limitations in many of our communities in the State.

We do not have any panacea answers as far as recruiting physicians for the small rural communities. It is our expectation that some of the things that have already been done, in some instances through legislation, will be effective. The most obvious is the WAMI program at Montana State University which annually gives Montana residents 20 places in the freshman class at the University of Washington Medical School. This program has not gone on long enough for any of us to know the ultimate results; however, we already see some graduates of that program back in practice in Montana in communities which would be considered to be rural by any definition.

It would make sense to us to attempt to recruit physicians for lifelong community living rather than placing rural health care physicians in these communities for 1 or 2 years while they are serving a mandatory commitment to the Federal Government and the Public Health Service. We have, for the past years, in our capacity as a peer review organization for the State of Montana, heard complaints from communities, hospital boards of trustees, and physicians that the present doctor or doctors in a community discouraged newer physicians from taking up residency. In some instances, physicians who left communities blame this on the presence of the older physician who "made things so rough." We are certainly in no position to comment with complete accuracy on any instances in which this has occurred. It is certainly true, however, that the community which has the support of the present physician or physicians when recruiting for new doctors will do much better than the community in which the doctor or doctors already present are not supportive.

In some instances, communities have recruited physicians because they feel that new doctors will give them broader 24-hour-a-day, 7-day-a-week physician coverage, or because they think their own community hospital will do better economically if there are additional physicians to refer patients to that facility. In some cases, the quality of health care rendered by certain physicians in certain communities has been questioned, and that issue has prompted boards of trustees and other civil leaders to seek out other physicians. The foundation has sent review teams into communities to advise these boards of trustees, community leaders and physicians on quality of care issues and physician/board relationships. We can only be effective in this capacity when we go into a community with the cooperation of both the medical staff and the facility. So many side issues are raised in any such a review in a confrontation between the medical staff and the hospital that, in our judgment, no one can be effective unless they are trusted on both sides. We would continue to be available for such consultation in the future, but again only when we have ready access to the complaints of both the medical staff and the hospital and, hopefully, can be considered to be a neutral party.

Staffing of smaller hospitals with health care personnel other than physicians is another problem faced by Montana and other rural States. In fact, staffing hospitals is a problem for some of our larger hospitals. There are no easy answers. In some instances, it will be necessary for licensing agencies to look at hospitals and make staff requirements that are compatible with what that hospital expects to offer to the public, and not continue to insist that they be staffed based on a Federal requirement that does not take into consideration the practical aspects of staffing a 5- to 10-bed, acute-care institution.

Most of our communities have elected to keep their acute-care facility. Many of our citizens recognize that, for some illnesses, they may be referred to larger facilities. On the other hand, all of us would prefer to stay and be treated at home as much as possible. It certainly is no longer possible to treat every illness of every citizen in his local community hospital. It should not be necessary then for that local community hospital to be geared up with equipment and the expertise to manage all illnesses. In some instances, it makes sense to staff with a combined staff a small acute-care hospital and the nursing home. If the local medical community feels comfortable in such a situation, innovations in Federal and State regulations will be necessary to insure that such can be done. We support the present cooperative effort between the State department of health and the regional offices of Health and Human Services in Denver to individualize licensing requirements for facilities based on what they themselves wish to be able to accomplish in the way of health care in the community. It is not good judgment to require the same level of professional help and supportive services in a 5-bed hospital as are required in one that has 150 beds.

The last legislature in the State passed a physicians' assistant bill which requires the State board of medical examiners to license physician assistants as a team along with their sponsoring physician. The physician is obligated to submit a plan to the board on how he or she proposes to use the assistant and, if it is acceptable, a yearly report on the progress as to how they are following the plan or wish to change. This, in effect, makes the physician responsible for the health care delivered by the health care practitioner who is serving under him or her. We strongly support this type of a legislative endeavor.

We do not believe that ancillary health care personnel, such as physician assistants and/or nurse practitioners, should be allowed to practice without such physician support. We do not believe that a community without a physician is better served by having a physician assistant and/or a nurse practitioner in the community who does not have adequate physician backup. We think that community is better off not having a physician and being forced to transport their ill to the nearest community that does have adequate medical care. In our judgment, physician assistants and nurse practitioners are not substitute physicians. They are trained to serve under the supervision of a physician. There are no shortcuts to a medical education.

We feel that the Federal Government should proceed quickly to put in place the swing-bed concept in health care. If there is one piece of legislation that would be immediately cost effective in this State, it would be this one. In many communities we see patients waiting 3 weeks before they can be placed in long-term care beds. During that period of time, they certainly have markedly diminished health care needs over what the majority of patients in the acute-care hospital have. If, on the other hand, the hospital is penalized on its medicare reimbursement formula, if they set aside some beds for these patients, then the system needs revision. It is certainly our hope that these problems can be resolved in the very near future and without economically injuring the acute care facility.

It is probably time that any small community which is asking for Federal assistance, either in staffing its facility or in finding physician personnel, fill out in detail a summary of their present health care capabilities, their plans for future development, and a commitment from the hospital board, community leaders, and physicians, if they are available, on their plans to cooperate with the Federal or State government, or private enterprise come to their aid in whatever their specific need is. Under no circumstances should a Federal program be placed in a community without very strong evidence of support. We have experienced numerous instances of dissatisfaction and outright antagonism between individuals involved with such programs in the past. In at least our three major medical communities, there aren't many things available that aren't also on a national basis. In the next level of communities, there are very few things that aren't available and for which the patient would have to leave their community. As we progress to smaller and smaller size, the broad spectrum of medical expertise in the community is certainly not the same. We will never have available the same medical expertise immediately available statewide. We can do a great deal, however, to insure that, barring absolutely impossible weather, good transportation is available to get patients to the appropriate medical facility when a catastrophe develops that cannot be handled locally. That is something that certainly should be encouraged in a State like Montana. We do not believe that a great deal of Federal legislation mandating which patient should be transferred is either appropriate or necessary. We have seen very few instances in which local physicians have been unwilling to transfer their acutely ill patients at any time they felt those patients' needs would be better served elsewhere. In fact, we believe that mandated transfer programs may actually hinder appropriate transfer. We have seen no evidence that would suggest that physicians want to hold onto patients locally who they know can be best treated elsewhere.

We certainly wish to thank the committee for this opportunity to share with you some of our thoughts on rural health care needs. We are strongly supportive of the presentation of Dr. Johnson. We are available to answer any questions we can, and if there are any which we cannot answer today, we will certainly try to find an answer and submit the requested information as rapidly as possible to the Washington office of Senator Baucus.

Senator BAUCUS. Thank you very much, Dr. Hayward. Because of time, I will not ask many questions that I otherwise might.

I think your statement covers a wide variety of points and is very helpful. Since you're with the Montana Foundation for Medical Care, though, I would like to ask you a question about PSRO's. Senator Durenberger will be active in this area, and, as you know, there are those in Washington who wish to repeal the PSRO's. I understand that all the PSRO's in the country were recently evaluated, and Montana ranked very close to the top. It ranked seventh in all those in the country. Of course, we in Montana think that ranking is in error, that we should be ranked first and not seventh. But, nevertheless, it is a good sign for the Montana PSRO's.

Because there is going to be an effort to repeal, or at least weaken, PSRO's in Washington, and because our experience here is very good, I wonder if you could put in the record, and also indicate for Senator Durenberger, perhaps indicate one or two areas where PSRO's perhaps could be strengthened. Where is there legitimate problem with PSRO's that perhaps we could strengthen a little bit so we could keep the system intact?

Dr. **Hayward**. I think that cutting down the number of PSRO's is certainly appropriate. I think New Jersey has six SPRO's. They certainly don't need more than one. I think that consolidation of PSRO's would help a lot. We are in total agreement that, in effect, that PSRO's should be eliminated from the program and supposedly be replaced by the older utilization reviews so that there would be a real comparison between the few different types of programs.

Many people have talked about regulations' entering activities in the health care field. We certainly have found that. A lot of the information that we were required to submit took 2½ days and two people in our foundation to fill out, and you might want to know this, or may know this; the first questionnaire came out, and a lot of people objected to it, and then we had new guidelines that we were supposed to use, but, anyway, it took two people 2½ days to fill it out, and a lot of the information we had already submitted to our regional officers in the form of quarterly reports, which, I think a certain number of the quarterly reports get filed in a certain file No. 13.

I think it would be helpful if we were allowed to be more innovative as far as some of the medical care evaluation studies that we are doing. We sold this program statewide to nationwide on the basis that this was a quality program, that there would be natural spinoff, that if the patient received necessary care at the appropriate level and it was of the highest quality, that had to be the least expensive way to provide health care. We shied away from putting dollar figures on it. We're now trying to develop some nationwide medical care evaluations so we can attach a dollar amount, too.

Senator **Baucus**. Thanks, I appreciate your statement.

As you know, I have introduced a bill which is somewhat of a compromise between the President's efforts to repeal and the present system, and the bill essentially helps to consolidate PSRO's in the State. There are presently 87 in the country, and I, too, agree that a few changes would be good for the system.

I have no more questions, but thanks.

Dr. **Hayward**. We appreciate your bill, Senator.

Senator **Durenberger**. I think I know, after a couple of hours, why the PSRO works in Montana, and that's because health care in this State is a very precious commodity, and when you have a very precious commodity, people will do anything they can to make sure that it is available and that it is affordable, and I just suspect, without knowing, just from listening to the conversation here, Max, in the last 2 hours, that that's one of the reasons that it works in this State, and both of those reasons are important.

Senator Baucus. There are other reasons, too; that we in Montana tend to know each other better——

Senator Durenberger. And trust each other.

Senator Baucus [continuing]. Than in other parts of the country.

Senator Durenberger. I will just add one thing very quickly, and this relates both to HSA's and PSRO's. People have to care about the costs of health care as well as the quality and accessibility, and that means the individual who needs care. It means the provider. It means employers of people who have to foot the bill for private insurance, and it means people in political areas. All have to care about costs and be willing to do something about it.

And one of the other things that I haven't had a chance to talk to, Max, is that I would like to explore, it terms of the future, both of community health planning and of appropriateness for utilization reviews, is dissolving it out of HHS and down to the State level so that Governors, with the help of the institutions involved, will start making some decisions about how to construct health planning in a statewide health planning concept; how, if at all, to fit certificate of need into that process, and where the PSRO concept works. And in all of that, it would mean that we would come into the system through medicaid and through medicare. We would not be funding the PSRO's or the HSA's. We just come in to the extent that we have something to benefit in terms of our program. But that means, in any given State, then, you have to have employers and people and so forth, Blue Cross, your insurers, people like that have to be interested in helping to finance the kinds of activities that this foundation in engaged in. And I am assuming—I'll put it in the form of a question—I'm assuming that if we made that kind of a change in both the system in Montana, it might work even better than it works under the present HHS kind of arrangement. Am I correct?

Dr. Hayward. I think the most important thing—this may sound a bit like we're after the money. If anybody thinks this has been self-serving to me and I made a lot of money in my almost 9 years, or 8 years as serving with the PSRO, it hasn't. I've essentially destroyed a practice. But you have to fund the physicians' time some way. Now if the States can't do it and if it's a combination of State and Federal, private review, which, I think, now, that a lot of large companies are beginning to realize the value of having appropriate review of the health care provided because it takes an awful lot of time. If you are not reimbursed with the physicians at least enough to keep their office open, they're going to get discouraged, and I don't know that it would work any better or worse. It has to be funded properly in order to exist.

Senator Durenberger. Thank you.

Senator Baucus. Thank you very much, Sterling.

Dr. Hayward. By the way, as far as this reimbursement to hospitals is concerned, I served on this great review board now for 6½ years. Just got fired. Jerry Levitt is in the room, and I think he and Billy Leary can give you a lot of information about the reimbursement problems.

Senator Baucus. All right. Thank you very much.

The next witness is Bill Leary, who is the president of the Montana Hospital Association.

You might note again, before the last witness, we had six witnesses to go and 60 minutes. Well, we consumed not 10 minutes but 20 minutes. The last witness has rather ominously limited the next witness's testimony.

Your testimony looks like a book, but I know you to be a man who doesn't mince words and is short and to the point, so I'd appreciate it is you could summarize, Bill, as best you can.

STATEMENT OF WILLIAM LEARY, PRESIDENT, MONTANA HOSPITAL ASSOCIATION

Mr. LEARY. Actually, the actual testimony is about six pages, Senator. The rest of it is addendums for both you and the good Senator to read on the plane going back to Minneapolis, and I do hope that you will.

[The prepared statement of William Leary follows:]

STATEMENT OF THE MONTANA HOSPITAL ASSOCIATION

INTRODUCTION

Chairman Senator Durenberger, Senator Baucus, Members of the Subcommittee and Guests, for the record I am William Leary, president of the Montana Hospital Association, appearing here today to express the views of the 61 general hospitals which comprise the membership of the Montana Hospital Association and more specifically, to express the views of the small, rural hospitals (under 89 beds) which represent almost 80 percent of the hospitals in Montana. We in Montana are truly a rural state with vast distances, a limited population and with a number of small communities spread out over our 147,000 square miles. Nevertheless, we are proud of our rural nature and I know the people in our state take a great deal of pride in the efforts of the hospitals to deliver a good quality of service at a most reasonable cost. We are currently ranked 50th in the nation in terms of the increase in hospital expenditures since 1967.

Yet, in spite of that undying pride, our small hospitals are in serious danger of not being able to survive over the next several years due to primarily three major reasons.

HUMAN RESOURCES

We currently lack sufficient qualified human resources to maintain, for the foreseeable future, service currently delivered in our rural communities.

Physicians—In spite of a general increase of qualified licensed physicians in Montana over the past four years, we still know of a number of communities currently being served by only one physician. All the national predictions seem to indicate there will be a surplus of physicians in this country by 1990, however, I state to you that many of these physicians will be reluctant to move to the small eastern Montana communities. It is not that they will not make an excellent living, as they certainly will have financial stability, but they will continue to suffer from professional isolation and the need of an additional physician to relieve them periodically so they can upgrade their skills.

Recognition by the medical profession nationally and in Montana of the ability of trained registered nurse practitioners to function within the small clinic as an assistant to the doctor could help alleviate the day-to-day stress felt by the sole practitioner. I would caution you, however, that the nurse practitioner should only be allowed to practice within a clinic under the guidance of a physician until such time as the federal and state laws are changed to remove the liability of the institution from the actions of physicians' assistants.

Registered Nurses—Montana along with the rest of the nation, is entering a period of a general shortage of registered nurses. Currently there is a need for nearly 300 registered nurses in our 61 Montana hospitals. While the nurse vacancies are greater in numbers in communities such as Billings and Great Falls, the small facility feels the shortage more acutely, as the R.N. in the small community not only provides good bedside care, but must also be well versed in intensive care, coronary care, obstetrics, surgery and also administration. The recruitment of the young single nurses to the smaller communities generally fails as they are usually reluctant to remain in a rural area on a permanent basis. Our small rural hospitals have consistently upgraded their salary and fringe benefit levels to meet and in some cases exceed those of the large facilities in order to attract the nurses to their hospitals. The shortages of personnel are not limited to R.N.'s alone as we see a shortage of lab technicians, x-ray technicians, etc., who all suffer from professional isolation and tend to leave the small community within a short time to further their professional careers. Effective, efficient management corporations operating under the general policies as determined by the local Board of Trustees, have been able in many of our small hospitals to assist the hospital to become financially viable again and in a better position to attract professional personnel. I express the view that these management fees should be fully recognized as a legitimate reasonable business expense in the various federal and state government reasonable cost formulas currently controlling the financial reimbursement of federal and federal-state patients. To do anything less is to remove management expertise so vitally needed for survival.

REGULATIONS

The Montana Hospital Association and its member institutions are encouraged by recent Administraton and Congressional initiatives to reform the regulatory process which since 1966 has grown to such a horrendous state that it is literally impossible for the administrators of small hospitals to keep track of and abide by the regulatory directives.

Over the past several years, the Montana Hospital Association has been involved in a study of the cost of regulations in health care facilities and has documentation which proves that a small hospital's adherance to many of the federal and state regulations does not at all improve patient care but does increase its operating costs by 20–25 percent. To illustrate the massive number of regulatory authorities with governance over hospitals, I have attached the Inventory of Regulations 1980 as well as the studies of cost regulations in health care facilities as received from various Montana hospitals. In general, we feel the Medicare Certification Standards must be reviewed and changed to take into consideration the particular problems of the under-50 bed hospital in meeting the regulations in terms of adequate manpower and financial resources. For example, Medicare certification requires that all hospitals have either a fulltime pharmacist a pharmacist consultant. It has been proven that in the small hospital or a pharmacist consultant does nothing more than visit the hospital two or three times a week for approximately one hour each visit, updates a card index, and does minimal dispensing. This is a task which any registered nurse in the hospital could handle more adequately if she were legally authorized to do so. For this service, a pharmacist usually recieves $400–$500 per month. We feel there should be some modification of this requirement so as to allow the head nurse in the hospital to carry out this function and handle the minimal dispensing of medications.

One 28 bed hospital was denied $6,800 in reimbursement because of the regulation which requires a registered physical therapist to be in the facility when a physical therapy aide is working with a patient even though the treatment being given is routine. This is lost revenue to the hospital in spite of the provision of a needed service ordered by the physician.

There are many other examples of regulations which affect the small hospital financially but provide no patient care and I encourage you to thoroughly study the attached documents for input as to the areas of regulations that we feel need to be changed.

REIMBURSEMENT

Perhaps the most unfair federal regulation facing all hospitals, but particularly small rural hospitals, is that of Medicare and Medicaid reimbursement. Of our 30 hospitals with fewer than 30 beds, 19 operated in the red in 1980. These hospitals had combined losses of $2,043,442 in 1980, of which $1,598,816 was made up by local government subsidies. The shortfall from Medicare and Medicaid for these 30 hospitals over the same period was $628,909 and $48,911 respectively. Hill-Burton free care requirements resulted in another $104,752 in loss of revenues. The bureacratic complexities of the Medicare principles of reimbursement have forced most hospitals in our nation to hire CPA controllers or to contract their accounting functions out to CPA firms in order to maximize the reimbursement under the Medicare and Medicaid programs. There are very few hospitals in this nation of 100 beds and over that do not currently employ a CPA. The small hospitals cannot afford the luxury of a full-time CPA and thus, due to a lack of expertise within their accounting office, are unable to maximize the reimbursement under Medicare and Medicaid unless they contract with a CPA or financial consultant for fees which range from $5,000–$15,000 per year. This cost of meeting expensive paperwork requirements does not improve the quality of care received by the patients.

Patient mix within the small hospital is a significant factor in the deficits experienced by the hospital. With a high percentage of Medicare and Medicaid patients and the unreasonableness of the reasonable cost formula, the hospitals are continually losing money under the Medicare and Medicaid packages. Left without a significant number of private pay patients due to decreasing occupancies, they are forced into a deficit situation.

The financial pressures on the small hospitals are also reflected by their expenses per patient day. The state average for all hospitals per patient day is $235. Even though the small hospitals under 30 beds have a narrower range of services, fewer personnel and less equipment, 9 of the 30 small hospitals experience costs over the state average. Expenses per patient day in these small hospitals range from $84.23 to $341.30. The average cost per patient day in the small hospital is $194.25. Their total expenses are 8.26 percent of Montana's total hospital service costs. While it is true that the cost of maintaining these services in a rural setting does not appear to be a problem in terms of the overall health care cost picture in Montana, it is however, a problem for the local communities forced to subsidize these hospitals which cover only 86.5 percent of their costs through patient revenues. It would seem to be more desirable as we enter an era of free market competition, to take an indepth look at the federal government's reasonable cost formula for Medicare and Medicaid and simplify it by reimbursing hospitals on the basis of a percentage of approved charges with approval of hospital charges to be granted by independent nongovernmental rate review systems. To counteract the possibility that charges could rapidly escalate, Congress could establish the criteria for the makeup and administration of the approved independent rate review organizations. A model which could be utilized is our own Montana Hospitals Rate Review System which has been in existence since 1969 and has had a vital role in the efforts of Montana hospitals towards cost containment and reasonable development of charge structures.

I have provided an attachment of our draft of a paper entitled "Medicare Reimbursement" and again encourage the members of the committee to read it carefully.

Some physicians, governmental agency personnel and politicians have expressed a fear that if we remove the tight bureaucratic and regulatory control over our hospitals and the health care system in general, that there will be an automatic increase in the number of patients placed in hospitals by physicians in order to accommodate hospital administration for a profit motive. I personally do not adhere to that fear but would suggest that Congress could, as a safeguard, stipulate that under the new Medicare and Medicaid reimbursement, a front-end yearly deductible could be required from all Medicare and Medicaid patients with the deductible large enough to discourage this action. This would be applied towards all provider services: physician, hospital, nursing home, etc. Thus, the patient would have to verify that they have paid the deductible before the Medicare and Medicaid agencies begin payment on bills. This would build into the reimbursement system the cost-sharing principles demanded by the taxpayer. The Medicare cost reimbursement method and the Medicaid open-ended reimbursement have proved to be too costly to administer both by the federal and by the state governments and has deprived the providers of adequate reimbursement needed to improve their services. It has unfairly switched the government's legal obligations to the private pay patients. Now is the time to seriously review the reimbursement program and make the necessary changes to take the reimbursement decisions away from the bureaucrats and back to the people who are getting the services.

SUMMARY

In summary I recommend that the Subcommittee on Health support the continuation for adequate funding of nursing education and to consider funding a program nationwide to retrain those whose careers have been dead-ended with retraining pointed towards a career in the health field.

I recommend that Congress support the deregulation of the health care industry by:

1. Supporting House Resolution 746, the Regulatory Procedure Act of 1981, and establish a commission to make a detailed study of Medicare and Medicaid certification regulations with an effort towards eliminating the bulk of the regulations which have little to do with the provision of quality care.
2. Taking a strong position to remove from the federal Medicare law the reimbursement based upon the lesser of reasonable costs or charges and move to a method of reimbursement based upon charges with proper state nongovernmental rate review bodies.

3. Taking necessary steps to change the Medicare and Medicaid programs from that of bureaucratic control of the health industry to a true insurance program for the elderly and the needy.

Thank you.

Mr. **Leary**. I am here today primarily to express some of the views of the 61 general hospitals in the State, but, more specifically, the small rural hospitals, those hospitals which are 89 beds and under which do comprise 80 percent of all hospitals in the State of Montana.

You've heard previous witnesses testify as to the large expanse of property that the State of Montans is composed of and the very restrictive numbers of population, and yet in spite of that and in spite of our rural nature, we have a great degree of pride, and the people of the State of Montana have pride in their hospitals. They know that the hospitals are consistently working to provide a good quality of care at a most reasonable cost. In fact, we are currently still ranked 50th in the Nation in terms of the increase in hospital expenditures since 1967. We attribute that to a lot of factors, a very effective cost containment program which has been going on even before cost containment was the byword in the State.

Yet, in spite of the pride of the people in their small hospitals, many of them are in very serious danger of not being able to survive over the next several years due to primarily three main reasons. First is the lack of human resources to operate the hospitals.

Physicians in the small rural areas are crucially needed. Still currently we know of many, many communities where there's only one physician. If a hospital or if the community loses that physician, the hospital, by necessity, must close. It's extremely difficult to attract physicians into many of our smaller communities, particulary in the eastern part of the State, and in spite of the national predictions which seem to indicate there will be a surplus of physicians by 1990, we still know that it's going to be difficult to get those physicians out there.

Facetiously I almost commented from the back of the room that perhaps we ought to change our way of recruitment. Because, in the past, we have had success in getting a male physician, primary care physician, to small eastern Montana and then have found out that the wife won't move there because of the disadvantages. Perhaps we ought to be recruiting women physicians and move them into eastern Montana, and then the husbands can do all the hunting and fishing they want to while the woman has something to do.

We do have to recognize, and the medical profession must recognize, nationally and in Montana, of the ability of trained, registered nurse practitioners to function within that small clinic as an assistant to the physician, because this could really alleviate those day-to-day stresses felt by that sole practitioner. I would caution you, however, that the nurse practitioner should only be allowed to practice within a clinic under the guidance of a physician until such time as the Federal and State laws are changed to remove the liability of the institution from the actions of pysicians' assistants. We're breaking ground in Montana, which you've just heard Dr. Hayward say, in developing some critertia for the use of physicians' assistants, and we anticipate that in about 1 or 1½ years, we'll be able to demonstrate how physicians' assistants and particularly nurse practitioners can even be used in the institutional setting under very strict guidelines.

Registered nurses, there is an extreme shortage occurring across the Nation. We're seeing it happen in our provincial State of Montana. We now know that right now we need at least 300 registered nurses in our 61 Montana hospitals. Now a nurse vacancy in a large community such as Billings and Great Falls is really not that crucial in terms of that hospital, but in a small facility, when they lose one nurse, that's a crisis situation. It's extremely difficult to find those kinds of nurses that will go into the small communities and not only give good bedside care, but will be able to function in intensive care, coronary, obstetrics, surgery, and even, in some cases, provide some administration. Recruitment of the young, single nurse to the smaller communities generally fails, as they are usually reluctant to remain in a rural area on a permanent basis. Our small rural hospitals consistently upgrade their salary and fringe benefits to meet and, in some cases, exceed those of the larger facility in order to attract the nurses to their hospitals.

The shortage of personnel is not limited just to RN's. We also see a shortage of other professionals, such as laboratory technicians and X-ray technicians. The major factor for both physicians, nurses, and technicians is not so much that of a financial situation, but is that because they all suffer from professional isolation, and they all tend to leave that small community within a relatively short time to move to other areas where they can pursue their own professional careers.

We have seen effective, efficient management corporations that operate under general policies and determined by a local board of trustees to be very effective in assisting the smaller hospitals to become financially viable and in a better position to attract professional personnel. We have been disturbed by developing national trends which seem to indicate that the fees paid to the Montana corporation will not be recognized as a legitimate, reasonable business expense from the various Federal and State government reasonable cost formulas, and we would hope that Congress, in its wisdom, would somehow indicate that this is a reasonable cost of doing business and should be recognized.

In the subject matter of regulations, the Montana Hospital Association and its member institutions are encouraged by recent administration and congressional initiatives to reform the regulatory process which, since 1966, has grown into such a horrendous state that it is literally impossible for the administrators of small hospitals to keep track of and abide by the regulatory directives. Over the past several years, the Montana Hospital Association has been involved in a study of the cost of regulations in health care facilities, and has documentation which generally proves that a small hospital's adherence to many of the Federal and State regulations does not at all improve patient care but does increase its operating costs by some 20 to 25 percent.

To illustrate the massive number of regulatory authorities which governance over hospitals, I have attached, in your folders, the inventory and regulations of 1980, as well as the studies of cost of regulations in health care facilities as received from various Montana hospitals. In general, we feel the medicare certification standards must be reviewed and changed to take into consideration the particular problems of the under-50-bed hospital in meeting the regulations in terms of adequate manpower and financial resources.

As an example, medicare certification requires that all hospitals have either a full-time pharmacist or a pharmacist consultant. It's been proven that in small hospitals, a pharmacist consultant does nothing more than visit the hospital two or three times a week for approximately 1 hour each visit, updates the card index, and does minimal dispensing. This is a task which any registered nurse in the hospital could handle more adequately if she were legally authorized to do so. And for this service, the pharmacist usually receives $400 to $500 per month from the hospital. We feel there should be some modification of this requirement so as to allow the head nurse in the hospital to carry out this function and handle the minimal dispensing of medication.

There are many other examples of regulations which affect the small hospital financially but really provide no patient care, and I encourage you to thoroughly study those attached documents for input as to the areas and regulations that we feel need to be changed.

Perhaps the most unfair Federal regulation facing all hospitals, but particularly small rural hospitals, is that of the medicare and medicaid reimbursement. Of our 30 hospitals with fewer than 30 beds, 19 operated in the red in 1980. These hospitals had combined losses of $2 million in 1980, of which $1.6 million was made up by local government subsidies, county and local government, bailing the hospitals out. The shortfall for medicare and medicaid for these 30 hospitals over the same period was $628,000, medicare; $48,000 for medicaid. This is not a significant number of dollars in the national arena, but certainly in terms of the small rural hospital, a little bit of money that the other private pay patients have to make up. It's not that the hospitals don't give charity; they do. The Hill-Burton free care requirements resulted in another $104,752 loss of revenues.

The bureaucratic comlexities of medicare and medicaid reimbursement have forced most hospitals in our Nation to hire CPA controllers or to contract their accounting functions out to CPA firms in order to maximize the reimbursement under the medicare and medicaid program. There are very few hospitals in this Nation of 100 beds and over that do not currently employ a CPA. The small hospitals cannot afford the luxury of a full-time CPA, and thus, due to the lack of expertise in their accounting office, are unable to maximize the reimbursement under medicare and medicaid unless they contract with a CPA or financial consultant for fees which range from $5,000 to $15,000 per year. The cost of meeting expensive paperwork requirements does not improve the quality of care received by the patients.

The patient mix within the small hospital is a significant factor in the deficits experienced by the hospital. With a high percentage of medicare and medicaid patients and the unreasonableness of the reasonable cost formula, the hospitals are continually losing money under the medicare and medicaid package; that is, losing money from their normal charge basis. Left without a significant number of private pay patients, due to decreasing occupancies, they are forced into a deficit situation.

The financial pressures on the small hospital are also reflected by their expenses per patient day.

Senator BAUCUS. Could you please summarize, Bill, if you could? We have a slight problem; Senator Durenberger has to catch a plane, and we have more witnesses to interview, and we have to shorten our time as much as possible.

Mr. LEARY. Sure. I'll drop it. You both can read it.

I would like, however, before I summarize, to simply mention that I think that Congress should probably take a look at the reimbursement formula, take a possible look at changing the reimbursement, reasonable cost reimbursement, to one based on the charge basis to turn the program around and make it a true insurance program. We have had it in operation in the State of Montana since 1969, and Montana hospitals' rate review system has proven to be a very effective cost containment mechanism, and we would hope that as Congress moves in this direction that they would consider the formation in each state of independent, nongovernmental review systems, and I would encourage you to take a look at our review system for the possible criteria.

In summary, I would recommend that Congress continue to support the deregulation of the health care industry by support of both S. 1080 and House Resolution 746, the Regulatory Procedure Act of 1981. We also encourage the establishment of a commission to make a detailed study of the medicare and medicaid certification regulations with an effort toward eliminating the bulk of the regulations which have little to do with the provision of quality care. I would also like to take a strong position to remove from the Federal medicare law the reimbursement based upon the lesser of reasonable cost of charges and move to a method of reimbursement based upon charges with proper State nongovernmental rate review bodies. I would also like to suggest that Congress provide the leadership in taking necessary steps to change the medicare and medicaid program from that of a bureaucratic control of the health industry to a true insurance program for the elderly and the needy.

And, with those remarks, I will close.

Senator BAUCUS. Thank you, Bill, very much. As you know, a lot of the requests you make are being taken care of; that is, we passed a bill a couple of years ago making medicare and medicaid regulations much more flexible to rural hospitals, and, as you know, with respect to reimbursement, it's on its way, too. It takes a matter of time for that to be put in place.

I don't have any questions except to say that your testimony is very helpful. We don't have the time to get into some of the points made by JoAnne Dodd when she talked about nurses being overworked and performing services in hospitals that aren't really proper for an RN or others to perform.

Nevertheless, I want to thank you very much for coming. You gave us a lot of good points. Thank you.

Mr. LEARY. Thank you, Senator.

Senator **Durenberger**. How strongly do you feel about the 8½-percent nursing differential?

Mr. **Leary**. Our position is that we feel that the 8½-percent nursing differential must remain until medicare turns toward a true charge basis.

Senator **Durenberger**. And you have no problem with prospective reimbursement, to give the States the ability to do that?

Mr. **Leary**. We have no problem, particularly in the State of Montana, providing that it is—I believe that it has to be utilized similarly to our rate review system, and we like the approach in Montana, which is an independent, nongovernmental rate review system, and they have the authority to indicate approved charges, and I believe we will see more efficiency in that kind of a method than during the current method.

Senator **Durenberger**. If we give you the administrative flexibility this year in the bill so that you can make some of those pharmacy changes as a State and so forth, that will make you a little bit happier, also?

Mr. **Leary**. Well, it will make particularly some of the smaller hospitals happy if we could get rid of some of those kinds of regulations which aren't really doing much except costing that hospital money.

Senator **Durenberger**. Thank you very much.

Senator **Baucus**. Thanks, Bill.

Next, Carolyn Squires, who is president of the Montana State LPN Association.

Carolyn, it's all yours. If you can, try to cut down a little bit.

STATEMENT OF CAROLYN SQUIRES, PRESIDENT, MONTANA LICENSED PRACTICAL NURSES ASSOCIATION

Ms. **Squires**. Mr. Chairman, I am Carolyn Squires, president of the Montana Licensed Practical Nurses Association. The Montana Licensed Practical Nurses Association wishes to thank you for the opportunity to comment on the concept of rural health care and how LPN's can better deliver health care services.

We are the professional organization which represents licensed practical nurses in Montana. Currently there are more than 3,000 LPN's in Montana and more than 600,000 LPN's in the United States. We have a keen interest and a great concern for those in need of health care services. We have observed firsthand the needs of the medically deprived who live in underserved areas of our country. We have watched as some of these health services have deteriorated because of the current Federal policy of not reimbursing providers with medicare funds and are fearful of the survival of health services in rural areas.

The Montana Licensed Practical Nurses Association intends to use this opportunity to emphasize our strong support for the reimbursement by medicare/medicaid of the LPN who provides services to patients in rural areas. You have heard the testimony and statements of many knowledgeable people. We are sure that you are aware that the administration has proposed, in the 1982 fiscal budget, that there be drastic cut in funds used to provide the coverage of services by nurse practitioners and physicians' assistants in primary health clinics. You also have available the reports of the Rural Development Subcommittee field hearings and of your colleagues on a subcommittee of the House Ways and Means Committee in 1977 in regard to this matter.

Our organization would like to go on record favoring the inclusions of LPN's in a reimbursement bill to correct the inadequate coverage of third party reimbursement and, indeed, would urge you to give serious thought and consideration to this as one possible solution to the problems of providing health care delivery in rural areas.

In 1977 President Carter signed Public Law 95-210 which amended titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic service. The law, as passed, did not include LPN's as providers eligible to receive reimbursement. However, the conference report included language which permitted LPN's, under certain limited circumstances, to be reimbursed for the services in rural health clinics. We now ask that LPN's be named as providers and that we be reimbursed for the services which we have been educationally prepared to deliver and are consistent with the Nurse Practice Act of our State.

As you are no doubt aware, there has been a steady progress and upgrading of the education and professionalism of licensed practical nurses. The licensed practical nurse profession has proven its worth in the pragmatic world of relieving human misery and suffering. We have been schooled in the basics of health care and nursing techniques in both the field and the classroom and exercised our training in various health facilities.

With the staggering workload of many physicians and their apparent scarcity in rural and other underserved areas, it would seem that other health professionals would be logical alternatives. These areas are under the supervision of physicians and are able to make better use of the sophistsicated means of communications now available. Care administered by health providers is often dictated by specialists who are many miles away. If we have these avenues available and can use them to lessen a medical problem or save a life, we ought to be progressive enough to make them legislatively and economically feasible and be able to implement them efficiently. There is always the danger that we will shun progress because we neglect to take a simple step or two that will aline the rules with the needs and solutions.

Modern day practical nursing has become more sophisticated in recent years. Our profession has come a long way since the time that just anyone could be called into a sick room or hospital.

The role of the LPN, as that of the registered nurse, has been changed dramatically in the past years. Many experts believe that the role of the LPN has changed even more significantly than the RN because the educational preparation has become more standard throughout the United States and now all 50 States require a minimum 1 year of practical nurse education.

Sadly, legislators and the general public have not kept up with the educational changes of the LPN and still think of her or him as a nursing assistant without formal education.

The fact of the matter, however, is that the practical nurse of 25 years ago has developed from an untrained person who performed relatively unskilled tasks for the sick in the home to fully responsible, specially skilled and licensed member of the health care team.

No longer do licensed practical nurses do the household chores such as cooking and cleaning, along with administering unskilled health care. Now she has studied for more than a year and has both a theoretical and practical training period.

After World War II, the U.S. Department of Vocational Education, in a special study, defined the duties of the practical nurse. The study also outlined the scope of knowledge the practical nurse needed and made numerous references to such terms as "judge," "recognize," "appraise," and "determine." Now virtually all States require that students pass a nationally standardized test to become an LPN. Also all States require graduation from a State-accredited practical nurse program in order to sit for the examination.

Generally speaking, LPN students must take courses in biology, physiology, and behavior sciences. More specifically, a typical practical nursing education program includes courses in anatomy, physiology, pharmacology, medical/surgical nursing, microbiology, nutrition, community health, human behavior, obstetrical nursing, pediatric nursing, and psychiatric nursing. Total hours of inclass preparation amount to 660 hours, 54 hours of laboratory house, and 832 hours for clinical training. This totals 1,546 hours of training. It should be understood that this preparation is not as extensive as the RN programs, but there are similarities in preparation for the various levels of nursing.

In 1981 we look to even a more humble rural health area and see it as a place where preventive medicine is routinely practiced, where treatment prescribed by a physician can be carried out according to his dictates, but does not necessitate his presence. The degree of excellence of the practical nursing course in accredited schools prepares dedicated people for their chosen occupation.

The needs in rural health areas are acute. Physicians, physicians' assistants, or nurse practitioners cannot handle all of the workload. One cannot fault the physicians for this situation. We need the help of every qualified health provider. The physician must work where he or she might be most needed, but to permit LPN's to be reimbursed would allow more physicians to share their time and expertise with other health providers who work in other health satellite units. This is one economical and efficient way to attack the perennial shortage of patient-serving personnel.

We fear the almost complete collapse of this fine network of medical clinics. Many of these federally established satellites will soon be forced to operate on their own as their seed money will no longer be granted. Also if the patients are not reimbursed by medicare, they will either not be able to pay for these needed services, or, worse, they will discontinue receiving nursing care.

Likewise, new costs will appear, such as the dollars needed for transportation to take patients to facilities where medicare will furnish services. Added to this will be the intangible cost in time and discomfort and treatment involved in transporting an ill person. It scarcely needs to be pointed out that there would be a toll in insecurity for people who may be aged and bewildered and in fear of the unknown and unfamiliar. Also it would be a traumatic experience for some of them to travel from their parochial surroundings. One can only speculate how many of these patients would simply ignore their health problems and cease to seek advice and treatment.

The new and needed approach of permitting third party payment seems to be a sensible solution to the problem of the lack of health care delivery. The inclusion of LPN's would improve this system.

The Montana Licensed Practical Nurses Association urges you to begin thoughtful and serious consideration of including the services of licensed practical nurses under titles XVIII and XIX of the Social Security Act.

Thank you.

Senator **BAUCUS**. Thank you very much, Carolyn. I think you make a very good point that a lot of the rural health care problems can be helped by providing more personnel, such as LPN's, and providing more services than is presently the case, and, in addition to physicians and RN's and physicians' assistants and nurse practitioners, that the LPN's can provide a great service, too.

The obvious question here, and focal point here, is to what education and services can all kinds of providers provide? We want as many people as possible to provide health care. We also want them to be trained and to be as well qualified as is possibly the case, and it's a never-ending quest as to how we do all that at the same time, and certainly I think it would be well for LPN's thus far, and I think that a lot of LPN services is not only a good suggestion, but I think it's one that we should pursue with more vigor than has been the case thus far.

Thank you very much.

Senator **DURENBERGER**. Yes. Thank you.

Senator **BAUCUS**. All right. The next witness is Rose Skoog, but I don't think she's here. Is Rose here?

[No response.]

Senator **BAUCUS**. All right. Next on the list is Alan Strange, Big Horn Health Corp., Montana Rural Primary Care Association.

Alan, we're happy to have and encourage you, if you can, to summarize your testimony, but we don't want to cut you off, so say what you like.

STATEMENT OF ALAN W. STRANGE, SECRETARY, MONTANA RURAL PRIMARY CARE ASSOCIATION

Mr. **STRANGE**. Thank you, Senator.

You have the written testimony, and I will just leave that as it stands. In the interest of time, I would like to make a couple of comments on things that have gone on here.

[The prepared statement of Alan W. Strange follows:]

STATEMENT OF ALAN W. STRANGE, SECRETARY, MONTANA RURAL PRIMARY CARE ASSOCIATION

The delivery of health services in rural areas, and in Montana in particular, is complicated by the great distances involved, and by the sparse population. These problems have been cited enough to become a litany, but they are seldom understood in a comprehensive sense, or considered in planning for the health needs of rural populations.

Low population density impacts delivery in several ways. Many areas have insufficient population to support physicians or dentists. Others have only enough to make a single practice economically feasible. Coverage for those areas means long hours and continuous emergency call, with little or no relief. Areas too sparse to support a full time provider must hope for an arrangement permitting clinic services to be offered a few days each week at best, and that means provider travel, further adding to working hours while reducing earning potential. At the same time, low population means fewer cultural amenities, smaller educational facilities, and a persistant problem with provision of activities and entertainment.

Hospitals in such areas tend to be small and lack the equipment considered standard in more urban areas. Specialists are many miles away. Interaction with colleagues and continuing medical education are more difficult and time consuming. Such a situation requires a type of practitioner who is quickly vanishing from the scene. Many of the practices in the state are staffed by single providers who have been in practice for a long time, and are approaching retirement age. Younger providers, who might be expected to fill those slots, have a greater concern for shorter hours and quality of life issues. These problems will not be solved by a provider surplus. Group practices are not economically feasible, and the insertion of providers into single situations which they find less than desirable means more provider mobility and disruption of care. Provision of relief by travelling providers is an extremely expensive and less then efficient solution. Quality of life issues tend to substantially modify the supply and demand forces one would expect to find in a free market situation. True, some providers will be drawn to such an environment, as they are now, and the numbers will be insufficient, as they are now. Provider surplusses come and go, but population density is a more enduring variable.

Problems of distance and population also affect those forms of health care usually provided by the public sector. Local health departments generally depend on the county tax base for funding. Mental health, alcohol treatment and ambulance services depend on a combination of local and state or federal dollars. The small rural hospital is often subsidized by the county through tax revenues. These services are extremely important to rural Montana. With long distances to large population centers, the rule, existence of small hospitals has often made the difference between life and death in emergency situations, as has a workable emergency transportation system. The majority of problems faced by rural residents are of a chronic, rather than an acute, nature. Hypertension, heart disease, alcoholism, stress related child and spouse, abuse, isloation, depression and substance abuse are serious problems in the state, and do not respond well to acute care models. Money spend on the outpatient treatment available through local mental health and alcohol centers is a cost savings device. One has only to look at the cost of treatment for such problems on an inpatient basis to reach that conclusion. Educational and preventive programs sponsored by the local health departments are equally efficient. And the local Public Health Nurse is the only consistent health care provider available to a large segment of the rural population. However, none of the services mentioned are self supporting, and funds are seldom available for more than one provider per county. Disregarding for a moment the low level of funding available, the distances involved create separate problems. As an example, our county is the size of the state of Connecticut. If all ancillary health care providers in Connecticut were quartered in one city, and all state residents had to drive to that city or each provider was expected to travel the entire state, transportation problems would be similar to those we encounter. The major area hospital is in the next county. I doubt that even Senator Kennedy, as much as he enjoys Massachusetts, would say that all the residents of Connecticut who required major surgery should be transported to Boston. Distance is expensive variable, both in time and expenses, whether the provider or the patient travels. Sometimes it turns relatively serious problems into true emergencies by adding to time of reponse and transportation.

The result of the constraints under discussion is that the provision of health care in rural areas is more expensive per capita than the cost of equivalent care in more highly populated areas. Provider relief, hospital maintenance, travel, and the cost of maintaining an adequate level of expertise for emergency response workers who may only see one case each month, all cost more than equivalent services in urban areas. Yet population levels and incomes are rarely adequate to support such a need. A working partnership between federal, state and local governments, providers and residents, and innovative combinations of provider networks, are needed to attack rural health care problems successfully. Each party must understand the nature of the partnership, and his responsibility to ensure its success.

It seems reasonable for government at all levels to provide assistance for the provision of quality health care. Certainly those people who provide tax dollars have a right to expect that those dollars will be spent in such a way as to promote the common good, and health care is certainly a valid and beneficial way to promote the general wellbeing. That is not to say that National health Insurance in some form should be instituted as a means of care delivery. It is to say that expenditures to maintain and improve the health of the population are a desirable end. Local governments in Montana have financed health services to the limit of their ability in most cases. State government is rapidly approaching the same point. Energy development has impacted Montana and is often seen as a financial cureall. That is an erroneous assumption. The health needs of the impacted population will surface long before the revenue arrives to ameliorate those needs. The federal appropriations for health care in this state are appreciated. Rural health care has historically received fewer dollars than its urban counterparts. In the last five years, our position has improved. However, a change in the federal funding available would seriously threaten projects which are becoming operational. In Montana, five of these projects provided health services to a total population of 133,000. Approximately 102,000 medical and allied health service encounters were provided for 35,400 patients using $839,000.00 in Grant funds. A cut in funding would threaten each and every one of these projects, and their ability to deliver health care to people who in most cases have no alternative care available. Grant monies in this case represented approximately $1.00 per capita for the state population.

Providers too bear their share of responsibility to assure quality care on a cost effective basis. In Montana, providers are meeting those responsibilities. Hospital, physician and dental charges in the rural areas are considerably lower than average. Coverage by health personnel is stretched thin and includes long hours of travel and emergency call. Volunteers donate extensive time to provide coverage for emergency transportation and other systems which would not otherwise be possible. With that effort, many areas in the state remain without essential health services.

The patient's responsibility for health care is as important as the other segments. Longer drives for non-emergent care in an area without urban congestion is a reasonable expectation. Education and training in first aid, self care and health enhancing life styles is also a means of working to improve delivery of care. Such knowledge, when acted upon, provides a means of reducing the threat of chronic or long term conditions, and permits provider time to be more equally distributed.

In an era of shrinking resources and increasing expenses, delivery problems may seem insurmountable. But there are steps which might be taken to reduce the rate of escalation of the cost of services in some areas, and to provide an outright reduction in others. They include:

1. Continuation of the National Health Service Corps and private practice option programs. These programs maximize the number of providers entering an area, thereby increasing the number who find the area attractive and decide to remain. They also provide a lowest cost means of subsidizing shortage areas which could not support a physician on fees alone, and could be used to provide relief physicians on a regional basis in a cost effective manner.

2. Merger of the adolescent, family planning, and educational components now addressed by federal projects into the established system of local Health Departments. Migrant health needs might also be addressed through this system.

3. Changes in the Grant Review Cycles and regulations for currently funded projects. Current review cycles now require yearly presentations of data which tends to be relatively stable. A streamlined review process for continuing projects would save money. As for the regulations, after spending considerable money to train providers, one is tempted to say either they should be trusted to practice in a competent manner or they should be fired and someone who is trusted should be hired to replace them. Quality health care is a desirable end, and the Congress needs to know that their programs are indeed reaching the people for whom they were developed. However, a more trusting atmosphere would permit substantial savings in the administrative costs for the programs under consideration.

4. Increased support for small rural hospitals through changed regulations. At present, there are conflicts with the Hill-Burton Act which preclude the housing of private practitioners in small hospitals. Those institutions house a wealth of under utilized providers and potential delivery systems. Many of the programs funded separately at present could be incorporated as hospital programs with a reduced administrative component and enhanced delivery capability.

The foregoing sounds like a plea for Block Granting, since in theory it would remove many of the obstacles under discussion, while providing local control of funding. As presented, however, Block Grants are not necessarily the panacea they appear to be. I know a man in Wyoming who once took off all his clothes and jumped into a patch of cactus. When they finally calmed him down and asked him why he did it, he said, "It seemed like a good idea at the time". So it is with the Block Grants. No control more local than the present Community Governing Boards can be provided by Block Grants. Without the specific designation of funds, such a program will almost certainly mean the dissolution of the programs under discussion. And the 25 percent reduction in funding we have heard of will come directly from the services now being provided. It is difficult for me to believe that the federal jobs now involved in the support of these programs will all be eliminated by

Block Granting, and I would hate to think that those positions will merely be reshuffled without real reduction while services disappear. We must find ways to conserve and reduce the expenditure of funds, it is true. But it can be done without disrupting the delivery of essential services to people who, in this case, have no reasonable alternative.

Mr. STRANGE. We have discussed distance and population and their problems of delivering health care in the State, and I would just like to give you a couple of local examples.

One, acute care and preventive care. We have, in our community, 5,000 square miles, and we have one public health nurse. We've heard testimony that——

Senator BAUCUS. What country is that?

Mr. STRANGE. Big Horn.

We have heard testimony that the majority of problems in Montana are chronic and long term, don't necessarily respond well to acute types of treatment, and, in that instance, the public health nurse is very often the only person, or at least the most visible person, dealing with the patients across the entire area. To expect on public nurse to be able to cover 5,000 square miles, regardless of the number of individuals involved, is somewhat wishful thinking, I think.

In acute care, in that 5,000 square miles, we have 1,000 people. In our ambulance service, we try to train EMT's. If we were training them in Chicago, after their initial period, they would go on duty and possibly get one, two, five calls a night. In Montana, they possibly get one call a week or less. Obviously, it's a cold way of looking at it, but those calls that the Chicago EMT's go on are additional training exercises that we're not lucky enough to have, or unlucky enough to have, as the case may be, so it costs us more to maintain an equal level of training with our EMT's as it would cost there. That money isn't necessarily available.

There is money coming into the State, and I would just like to talk a little bit about what we spend our money on. We have people who write grants, review grants, recommend grants, evaluate grants, approve grants, fund grants, and manage grants. We have created an entire new class of professional, that person like myself, a professional grant writer and project administrator whose job it is to, in the first place, get the money to the community, and, in the second place, make sure that we continue to comply with the everchanging regulations so that we can keep the money in the community, hopefully to provide services to people who otherwise would not have any. Obviously if there were fewer regulations or less conflicting regulations, the community and the Federal Government, by extension, could at least save my salary and the salaries of people like me and still, hopefully, be able to provide the same level of services.

There are two established groups in Montana, communitywide, who are not only based in the community and made up of community members, but already are rural health oriented, and those are the local health boards who govern the health departments and the governing boards for the local hospitals. In the past, there hasn't been much of an attempt to work through those two boards, and I believe that Federal dollars could be more equitably used, perhaps, with more emphasis on self-care, educational programs, and ancillary care programs provided through those local health departments and the local small rural hospitals; self-care programs, obviously, to give the patient some way of dealing with his health problems until he can get to a physician or other health care provider, and ancillary care provided through the local hospitals becuase it's only by branching out that some of these small hospitals can retain their precarious hold on financial solvency, as it is.

In addition, I think the Federal dollars could be spent on preparation of local quick response units, and EMT's would become ever more important as the distance grows between secondary and tertiary care centers. We have found in the State that people are willing to work long hours as volunteers with no money, and it seems a shame not to take advantage of that by providing them with the equipment with which to work.

Telecommunications systems are necessary, I think. We've heard testimony from some other sources on how expensive they are. They're certainly no more expansive than some of the other ways that we spend money in an attempt to provide services, and they have the advantage of allowing personnel on the fron line level to remain in communication with physicians in hospitals who can be centralized in an area.

I don't want to take up any more of your time. I would be happy to answer any questions that you have.

Senator BAUCUS. I have a question, Alan. As a professional grantsman, how much can be cut back in terms of regulations and paperwork? And that's the usual question everybody asks. We all talk about, I think this year, doing something about it. But from your perspective, speaking candidly, what percentage of the paperwork that you fill out and work with, and regulations that you've involved with, can be cut back and not cut back health care?

Mr. STRANGE. One hundred. Let me explain that.

One of the problems of living in a very small area is that people who work in administration, in almost any area, are generally overworked. In a more urban area, probably that wouldn't be the case, but in our area, if it weren't for these regulations and a granting cycle, the job that I do could basically be handled by someone in the local health department of the hospital administrator who already have to be on the job, and my entire salary could be saved.

Senator BAUCUS. But isn't there a place for regulations to help prevent some abuse of expenditures?

Mr. STRANGE. Yes. I think there's a definite place for regulations. The regulations don't have to change every year, and the grants don't have to be on a 1-year cycle. We're dealing with relatively stable problems in stable areas, and the amount of time that's spent reiterating those stable problems on an annual basis could all be saved.

Senator DURENBERGER. In the whole area of who do you trust, to the degree that we're talking about it here, someone earlier made some comments about county commissioners, and I'm not sure how public service is organized in Montana, but if we took your discussion and utilized some of the local health board resources, would we run into problems with people who care about raising funds and so forth than really care about delivery of health care?

Mr. **Strange**. Well, I can only speak from my own personal experience. Our county commissioners have been very willing to listen to proposals for health expenditures, and they've been very willing to turn over the responsibility for watching those health expenditures to people who either have experience in the area or are on a volunteer basis and are willing to take their time and look into those things. Our health board, at present, has no county commissioners on it. Our hospital board has one. But basically we have, on those two boards, 11 people who all have other jobs to do and who are willing to take their time because of their interest in the field.

Senator **Durenberger**. OK.

Mr. **Strange**. You can't get any more local than that.

Senator **Durenberger**. Thank you.

Senator **Baucus**. Thanks, Alan, very much.

Our final witness, on the list anyway, is Jim Foley, who is the executive director of the Montana Health Systems Agency.

STATEMENT OF JIM FOLEY, EXECUTIVE DIRECTOR, MONTANA HEALTH SYSTEMS AGENCY, ACCOMPANIED BY BERT GLUECKERT

Mr. **Foley**. You may notice, I'm bringing the biggest guy in the room [Mr. Bert Glueckert].

Senator **Baucus**. That's terrific. Thanks, James.

Mr. **Foley**. Thank you for the opportunity to talk to you.

Senator **Baucus**. You bet.

Mr. **Foley**. I will make it very brief.

When I was called by Debbie to make 50 copies of this, the last time I made 50 copies of anything was my thesis in college, and the only one who read it was my mother, and she didn't like it.

[The prepared statement of James H. Foley follows:]

Prepared Statement of James H. Foley, Executive Director, MHSA

Senator Baucus, Senator Durenberger and staff: Thank you for the opportunity to testify before your subcommittee. I am James H. Foley, Executive Director of the Montana Health Systems Agency. I am speaking for the Montana Health Systems Agency. Also present and available to answer questions is Bert Glueckert, Director of Health Plan Implementation for the Agency, and John Allen, Secretary-Treasurer of the Governing Board of the Agency.

Why in the hell would anyone want to be Director of an Agency such as the Montana Health Systems Agency, which appears at times to be labeled the enemy?

Having been the Director of the Health Systems Agency for only three weeks, many of the opinions I express in this report are personal opinions. These opinions have their origin from my involvement in the health field for ten years and are opinions shared by many of those involved in the Health Systems Agency. Most of the problems we are faced with have been with us for a good many years and didn't start last week when I arrived at the HSA.

I believe I have paid my dues to be the Director of an agency such as this, to try to bring some order out of the chaos that exists occasionally in the health system. I was in business for 19 years in Helena and for the past nine years was involved in health planning and the administration of a mental health program in Southwestern Montana. Following this I was involved in a manpower program with mental health.

For the past six years I have served on St. Peter's Hospital Board, governing the operation of Helena's only hospital. Previous to that time I was President of the hospital board for a Catholic hospital in Helena. The hospital has subsequently closed as a result of different factions, one of which was trying to cope with State and Federal regulations.

About two months ago I attended a meeting at Sun Valley, Idaho, for medical doctors involved with hospital boards and hospital board members. This was an instructional seminar on how to improve the efficiency of hospitals and continue to improve medical care.

The principle speaker was the Dean of the University of Minnesota Medical School, who believes that within the next two years the health field will change 180 degrees from what now exists. He have as an example the changes which will affect the consumer since the costs of medical care will become a function of what the patient demands. If a patient demands merely a shot of penicillin, then eventually that's just what he's going to get. The predictions are that we will continue to have an increase in vacant hospital beds.

Having been raised in Anaconda, under what I call a "we" and "they" philosophy, it seems to me that most of my life I have been faced with this philosophy. While shoveling iron balls in the smelter, it was "we" who were doing the shoveling, against "they", the Anacondia Company. In the service, it was "we" in the Air Force, against "they", the enemy. In business in Helena, it was "we" who were in small business, against "they", the establishment and the banks.

As I listen to this group discuss rural health, I feel that now I am not in a "we" and "they" philosophy. Rather, I'm in a "we" situation, where we are all trying to accomplish something for the rural areas of Montana, and that "we" are all very conscious of cost effectiveness.

One of the first things I hope to accomplish as Director of our HSA is to coordinate the activities of the HSA with the Montana Foundation for Medical Care, the Montana Hospital Association, the State Health Department, the Montana Nursing Home Association and other professional and consumer organizations involved in health care. I realize that this is a large task, but hopefully, not an insurmountable task. It is my fond hope that since most of these people in this room and those involved in the health field are friends, they will assist me in trying to accomplish just this type of cooperation. The only ulterior motive I have in stating the above is that we will be able to eventually demonstrate an impact on the health systems of Montana.

The Health System Agency, by law, has four main goals:

1. Improving the health care of area residents,
2. Increasing the accessibility, acceptability, continuity, quality and effectiveness of health services,
3. Restraining increases in the cost of health services, and
4. Preserving and improving local health care competition.

At the present time, the Health Systems Agency for Montana has 135 persons directly involved in the decision-making process for health care. These people include bankers, lawyers, merchants, housewives, university professors, nurses, doctors and representatives of almost every walk of life, from every area of the state. These people volunteer their services to provide consumer input into the decision-making process of the Health Systems Agency, with the principle goal in mind of improving the health care system for our state.

The health problems of rural America are currently receiving increasing and necessary attention from planners, practitioners and researchers in the health field. We have come far, but we have a long way to go. The tendency to see cities as the focal point for the most pressing social and health needs is changing because rural populations experience even higher rates of health-related problems. Rural populations are composed largely of the aged, the poor, and in Montana, many Native American minorities are identified as being at a particularly high risk for health problems.

Despite this high level of need, the capacity to solve the problems of health in rural areas has been limited. There is widespread poverty in many rural areas, low population densities, inadequate transportation networks, and a shortage of trained health and mental health personnel.*

The tapestry of rural America is one whose design is difficult to describe. While at some point in our history the word rural may have had a uniform meaning, this is certainly not the case today. Health administrators and policy-makers in Washington have a tendency to look at rural in the terms of the small farms and villages of the South, Mid-west, or New England states. But the rurality of the West and of Montana, in particular, is nothing like that which we find East of the Mississippi. The vastness of Montana is difficult to comprehend by an Easterner. Senator Baucus, about two years ago while speaking in Great Falls, gave the example that it would take the combined populations of Montana, Idaho, Wyoming, North Dakota, South Dakota and Utah to match the size of metropolitan Detroit. The eastern 17 counties of Montana, with an area the size of Pennsylvania, contains fewer than 100,000 people. It would take the combined land areas of Massachusetts, New Jersey, Michigan, New York, New Hampshire and Maryland to equal the size of

Montana, while the combined populations of these states is almost 70 times the population of our state.

These statistics have been recited numerous times. But the important thing to consider is that as a result of these factors, our problems and our needs are different. The social and economic cost of space is a problem not to be taken lightly. The different problems and needs between urban and rural people are a major factor on many fronts—transportation, housing, energy and health—and needless to say, these are not independent areas of concern. They have a profound effect upon each other. The infant mortality rate in rural, medically underserved areas is nearly three times the national average. Deaths in childbirth are nearly double the rate of urban areas. Untold numbers of rural communities are without doctors. Far from being the haven of pastoral calm that we stereotype it to be, rural America abounds with the most dangerous of professions—mining, forestry and farming.

All these factors are complicated by the shortages of health manpower evident in rural areas. Not only do rural dwellers have far fewer physicians per 1,000 population than do city dwellers, but the average age of the rural physician is older than that of urban doctors. The problem is getting worse, only four percent of those graduating from medical schools in the past year chose to live in rural areas.

As I've already mentioned, rural areas have a disproportionate number of older persons and poor persons than do the urban areas. The old and the poor have need for more health care than the young and the middleclass, but have less available.

In conclusion, how can the problems of rural life be overcome and the many positive aspects be utilized for the provision of health services in Montana?

To begin with we need emphasis on maintaining health in addition to the present emphasis on treatment of illness. It is far easier to train, recruit and reward health educators, nutritionists and paraprofessional community care providers than to continue to concentrate upon the physician as the only provider of health care, and the hospital and clinic as the only setting. Maintaining good health should, and must be a family and community goal. Family members should be offered training in such fields as nutrition, exercise and home health care.

You have my pledge that the Montana Health Systems Agency will work to restrain increases in the cost of health care services. We will work toward the maximum utilization of hospital beds in all areas. The HSA will continue to recommend a flexible swing bed philosophy with minimul regulations so that we can take full advantage of each available bed in the state.

We will work toward a consolidation of programs involved in health, such as mental health and drug and alcohol services, to minimize duplication, and have them administered in such a way that a person in need can get all the help he desires in one setting.

We will work to become involved in the rate review system, and toward not only an appropriate review system for projects in the state, but also to solicit the cooperation of the State Health Department and all others involved in health care.

To those hospitals desiring technical assistance, we will attempt to give that assistance in any way possible.

The Health Systems Agency has the ideal mechanism to assist Governor Schwinden with the Block Grant philosophy that he is now confronted with.

Gentlemen, I ask for your support in assisting the Health Systems Agency to carry out its functions.

Thank you for this opportunity to share thoughts on the rural health care needs in Montana.

Mr. FOLEY. I've been on the job as director of HSA for 3 weeks, and I've been asked in this room a number of times why I would do such a thing, and my wife seems to think it's because I lost a bet on BYU and Notre Dame recently.

However, I have been involved in the health field for the past 15 years as a board member of St. Johns Hospital in Helena, which eventually closed because they could not cope with many of the problems that exist today in the health field, and recently, for the past 7 years, I've been on the hospital board of St. Peters Hospital in Helena.

I feel very strongly that in the time we have, whether it be short span or long, we would have some impact on the system by bringing about a consolidation of effort, and I say this only after you have listened for the past 3 hours to various people give their opinions as to how we might improve health care in Montana, and I do strongly believe in the "we" philosophy that if we all do this together, we can improve the health care system.

We hope to consolidate our thinking in our appropriateness review to include such things as a more appropriate review with the Montana Medical Foundation, the Montana Hospital Association, the nurses association, and all people involved, either professionally or paraprofessionally in this field. The health systems agency has four main goals, as Senator Durenberger may have referred to previously; of improving the health care of area residents; of increasing the accessibility and acceptability, continuity, quality; and effectiveness of health services; restraining increases in the cost of health services; and preserving and improving local health care competition.

At the present time our agency has 135 people involved throughout the State from every area, and these people include doctors, lawyers, nurses, bankers, merchants, and consumers from every walk of life. We feel that this is an excellent way to help us in the appropriateness review process, and, Senator, I was going to quote you extensively from a speech 2 years ago, but I can't do it now.

To begin with, something that has not been mentioned to any degree today, as I believe personally, that we've got to talk more about maintaining our health. We have to have emphasis on maintaining health, in addition to the present emphasis on the treatment of illness. It is far easier to train, recruit, and reward health educators, nutritionists, and paraprofessionals than to continue to concentrate on the physicians as the only provider of health care and the hospital and clinic as the only setting of health care. We have to continue to work at maintaining good health, and it must be a family and community goal.

The health systems agency in the next time that I am here will continue to recommend a number of things which have been discussed in this room, one of which is the flexibility of the swing bed concept that Senator Baucus has referred to many times. We will work toward a consolidation of programs involved in health and mental health, drug, and alcohol services to minimize duplication and attempt to recommend to the administration these programs in such a manner that a person in need to get this help in one setting. We will work toward becoming involved in the rate review system and toward a better appropriateness review system for projects in the State. We will also solicit advice from the State department of health and environmental sciences how we could both cooperate and do a better job in this appropriateness review. We hope to be able to give technical assistance to hospitals who are asking for appropriateness review.

I believe that the health systems agency is the appropriate unit to handle the block system grant philosophy that is going to exist very shortly because it is one area where all people are represented throughout the State.

I thank you very much.

Senator BAUCUS. Thank you very much, Jim. I sometimes hear that HSA's in the State are a little bureaucratic; there are too many levels, you have to go through the regional HSA and go to the State, and it just takes a lot of time and redtape. I don't know the degree to which this criticism is valid—I have no idea—but on occasion, I won't say that it's overwhelmingly great from the figures that I've heard, but on occasion it comes up, and I wonder if you could address that point.

Mr. FOLEY. I wouldn't even attempt to argue that on some occasions it has been a very arduous type of a review process, but, in many cases, it has been necessary to be that thorough, and we hope to continue to improve it. Like all agencies, we are going to try to continue to improve and step up the efficiency of the operation so that it won't be a long delay between the application and the acceptance and so forth.

Senator BAUCUS. Do you have any suggestions as to what changes, if any, should be made in legislation to provide for HSA's?

Mr. FOLEY. I really would not like to comment, because at the end of 3 weeks, I would rather find out a little bit more and then appropriately write to you with my recommendations.

Senator BAUCUS. I can very much understand and appreciate that. If you can, think about it a little, because it would be helpful.

Mr. FOLEY. We have recommendations that we would like to recommend, but like all organizations, we would like to review them with our governing board before so doing.

Mr. GLUECKERT. Senator Baucus, one of the areas I feel should be looked at in terms of the regulations that the HSA follows is in appropriateness review. I have worked with this program since it inception, and they are very hard to follow. They are very hard to implement, and we have done our best so far to live up to the rule of law, and that's been nearly impossible because we've had to implement regulations that are essentially accomplished in other phases of our duties, and that is in writing our health systems plan. So from my end of the health systems agency, I would suggest that appropriateness review be analyzed once again and changed to fit the needs of rural citizens.

Senator BAUCUS. On occasion I also hear some comments that the composition of the group is weighted too much one way or another. They don't have the right people on the board or making the decisions.

Mr. FOLEY. They made a great decision when they hired me, and I think, they're great.

Senator BAUCUS. I'll agree.

Mr. GLUECKERT. I think the composition being over 50 percent consumer and the remainder being provider is an excellent composition, because this gives input from all facets of citizens and not just administrator or physicians.

Senator BAUCUS. Thank you very much.

Senator DURENBERGER. What does it cost to run a 135-person agency, manually?

Mr. GLUECKERT. We don't run a 135-person agency. Those are the consumer and provider people that have volunteered their time. We have a staff of approximately nine people right now, and we operate on a budget of approximately $350,000.

Senator DURENBERGER. Is that all Federal money?

Mr. GLUECKERT. No, it's not. We receive some State moneys from the State.

Senator **Durenberger**. What would happen if we dropped out of funding in Montana?

Mr. **Glueckert**. If you dropped out of funding, our agency would go belly up.

Senator **Durenberger**. Why?

Mr. **Glueckert**. There is not enough support, at least at the present time, either in the State government or locally to maintain the staff, nor pay their volunteers their per diem costs. So it's very important to us to have the Federal money.

Mr. **Foley**. Senator, one of the reasons that I did this is I felt I could make it survive, in one way or another, and in one form or another I feel it should survive, and I felt I had the balance to make it survive.

Senator **Durenberger**. Well, that's fine. You maybe in part answered the question when the young man says there's only nine people trying to make this process work, even with the 135 people you have advising you, but, you know, if three-quarters of a million people in this State don't care, and the Governor doesn't care, and the county commissioners don't care, and employers don't care, and all the consumes don't care enough to fund whatever it is, something less than $350,000, to work at a process that is supposed to access more people to affordable health care, the why should I or Max impose the system on all those people?

Mr. **Foley**. You're asking me? You've got to catch a plane. [Laughter.]

Mr. **Foley**. And you're going to be late if you keep this up.

But I feel there is an interest in this or there wouldn't be this many people in the room coming to talk to you this date. And the system is such that this is how it was started, with Federal money and State participation minimally, but there hasn't been any opportunity to really check into all of the other methods of a possibility of survival.

Senator **Durenberger**. Well, my problem, as Max pointed out earlier, our problem is that we are fighting to save what we think are good concepts. Maybe in some parts of this country it hasn't worked well. Maybe in some places it wasted a lot of money and so forth, but the concept of community health planning and the concepts of utilization of appropriateness review and so forth, I think, are things that we believe in because where they're worked well, they're good. But I'll tell you that the pressure is incredible from the President of the United States, who exerts pressure pretty well on down to say, "Get rid of them. They don't work."

So I need something more than, "Yeah, it would fall on its face because Montana can't come up with, or the employers of Montana, or whoever else as a State, holding these costs up, can't find the money."

Mr. **Glueckert**. All right.

Senator **Durenberger**. So maybe you can work on that.

Senator **Baucus**. I think in part, though, the answer is your earlier observation; that health care is such a precious commodity here, and resources are fewer, and that's, in part, why it doesn't work in some States and does work in some other States. Maybe the answer, then, means taht we should take some of the money away from the other States.

Senator Durenberger. Keep your severance tax for a while.

Senator Baucus. That's right.

Well, I want to thank you both very, very much for coming, and everyone else who testified here.

Thanks, too, to Senator Durenberger, who has come out here to visit with us. I think he's learned a lot.

And thanks also to some of the staff; John Kern of the Senate Finance Committee staff has been very helpful, along with Bob Hoyer; Debbie Landau, of my personal staff. And I also want to thank Barbara Gray and Sharon Peterson and others in my Billings office here. And JoAnn, too; JoAnn has been the stenographer here. She has been very helpful in dutifully and uncomplainingly putting down all of this for us for posterity.

Thank you all very much.

[Whereupon, the hearing was adjourned at approximately 12:30 p.m.]

[By direction of the chairman the following communications were made a part of the hearing record:]

Statement of Michael B. Evans

Good Morning! For the record, my name is Michael B. Evans and I am Associate Director of Montana Wyoming Health Resources, a non-profit organization that works predominately with small and rural hospitals in Montana and Wyoming.

The remarks which I make this morning are not new. They are lamentations that have been given in the past. I am going to assume that the reason nothing has been done about these problems in the past is because you haven't personally been made aware of them. Consequently I will risk being redundant and restate some items that are important to the future of hospitals, including and especially small and rural hospitals.

Initially, by way of illustration, let me use an analogy that has been used before. All of us are familiar with out local grocery store. Other than hospitals, it is the only service that the use of which we rely solely on our body systems to decide.

To begin with we will modify the way in which our grocery store must function. First we must establish a few "authorities" to oversee the operation. These "authorities" will "promulgate" (borrowed from the federal register) some rules and regulations. To fully appreciate the analogy, we will introduce a third party who is independent from the store and its authorities. To this independent we shall delegate, or relegate, our decision making power over when we can enter the store and the nature and extent of our shopping spree. There will be a direct relationship between this person's income and the extent of the shopping sprees on which they send us. This person will also determine how many will shop at a given time and at which store.

Now let's look at some of the rules under which the store must now operate:

1. The store must certify in writing that each customer "needs" groceries before permitting him/her to enter the store. The determination of "need" is solely at the discretion of the independent. However, should the authorities decide retrospectively that "need" did not exist, they will pay the independent but not the store.

There are provisions for "emergency" shopping sprees. In this case, the independent can again assist you in your shopping spree. However, if the authorities decide you weren't really hungry, the store is left to tell the shopper that they did not need to eat, the authorities will not pay the store, but they will pay the independent.

2. The store must have a "committee" to establish a shopping "time limit" for each customer as he/she walks in the door. Any customer permitted to shop longer than the pre-established time limit, may not be required to pay for the groceries. The store must keep records of this by customer.

3. The store must obtain approval of the "authorities" before adding or deleting any product or specific brand of product.

4. Periodically, the store will be required to determine and report "race" of each customer in the store during a particular day. However, the store may not ask the race of any customer, nor ask leading questions that indicate an attempt to determine race.

5. The store must keep a record, by name, of time customer entered store, items purchased, amount paid by item, name of stock boy who placed each item on the

shelf, time of customer departure from store and name of store employee who carried the groceries out.

6. The store must record and report each year the number of cans of peas sold, by brand, by customer age, and by employer of the customer. For example, report sales of Green Giant peas to General Motors employees, and so on. Next, Sunkist peas, ad nauseum. We will require this not only on peas but on every product sold.

7. The store must keep records and report the following to the "authorities":

a. Total number of customers served, broken down by employer.

b. Total minutes of customer shopping.

c. Number of customers who used shopping carts.

d. Number of customers who did not.

e. Number of customers who bought meat and nothing else.

f. Number of customers who bought bread and nothing else.

g. Number of customers who bought milk and nothing else.

h. Number of customers who bought bread and meat.

i. Number of customers who bought meat and milk.

J. Number of customers who came in for one item only but who bought two or more.

k. Number who went directly to left side of store upon entering.

l. Number who went directly to the right side upon entering.

m. Number who sauntered down the middle ailse.

n. ETC.

8. Now the authorities will mandate that the store must give away a certain amount of groceries each year. In fact, let us force the Store Manager to post signs in three languages telling customers that he is required to do this; and again, records must be maintained by customer on free groceries given away under this plan, as well as records on those denied. Lets further require that should the store not give away as much as the authorities determine is reasonable, lets require that the store go out and find people to give groceries to.

9. Next, let's require that for one half of the store's customers, the store cannot set prices. Instead, our authority will determine how much the customer may be charged. Better yet, we will tell the manager that these customers may be charged no more this year than last year prices—regardless of how much more regulations and inflation have added to our costs. After all, the store can increase prices to the other half of its customers to make up for any losses.

10. Naturally, we must also establish that the store and its manager will be fined if it refuses to report the data we have outlined or its records are not totally accurate. We will also give each authority the latitude to determine its own data needs.

11. The store must also hire an independent account to certify the accuracy of data reported under our regulations.

12. For good measure we will also make the store manager responsible for planning each customer's meals. If he/she errs in the determination of what is best for a family then the family can sue.

All of this sounds ludicrous doesn't it. Unfortunately it only scratches the surface of what hospitals must face in their current operating environment. Hospitals must:

1. Report monthly and annual days of inpatient care, by age group, by services (medical, surgical, pediatrics, etc.), by type of financial coverage.

2. Report out-patient services in a similar fashion. Emergency visits in a similar fashion.

3. Report annual minutes of anesthesia administered.

4. Report minutes of operating time.

5. Report number of transfusions, x-ray exams by type, lab tests by type, physical therapy treatments by type, etc. for all departments.

6. We must establish time limits for hospital stays by diagnosis.

7. ETC. We could go on foreover showing the similarities and how much further hospitals must go, beyond our "ludicrous" illustration.

As you know, New York State did a study of what regulation was costing them. They estimated that enough person hours were dedicated to regulations alone to staff 75, 250 bed hospitals for a year. At a cost of $125,000 per hour. The forms cost alone were estimated to be $128 million. As I mentioned in our illustration, it is not enough that we face this pile of paperwork from one authority, but we must face it from a multitude, all having "reasons" why they must have the data reported in their format.

To provide some specific examples: One hospital we work with recently got a 2½ page letter requesting substantial additional information they "must" have before a final determination could be made as to how poorly they were going to reimburse the hospital. In the final paragraph this "auditor" states "In the course of reviewing cost reports and financial statements, it is not uncommon to note items which, although they have no direct bearing on Medicare reimbursement, none-the-less seem quite unusual." In other words they want all this additional information just because they want it, and we won't get paid until they get it.

Another of our more rural and remote facilities recently had a team of five persons fly from HHS office in Denver to survey the Hospital. This is a sixteen bed facility that averages 3 to 4 patients a day. They could operate for a month on what it cost to have this team come out and do a survey.

These problems are further exacerbated by the lack of flexibility in the current system. Hospitals function under the same rules and regulations whether they are six beds or six hundred beds in size. Cost reports are a prime example. Every hospital files the same morass of paperwork regardless of how inapplicable much of the information may be. This leads to the establishment of departments that exist more on paper than they do in actuality, and leads to, in the case of one of our hospitals, a hospital wasting time trying to divide up 18 cents to meet reporting requirements. These same kinds of inflexibility also extend to physical plant and provision of services.

There are also some current, and very real policy decisions that are hurting the small hospitals in Montana, particularly those that are combined hospitals and nursing homes. The aged population in Montana, and most specifically in rural areas, is dramatically increasing. It is estimated that by 1985 the aged population will be as high as 14 or 15 percent of the total population. The 75 and over age group is the fastest growing segment of this population trend. These people typically need the most care from our medical care institutions and have the least resources to pay for this care, whether this be from physicians, nursing homes, or acute hospitals. These people are not going to suddenly evaporate simply because of a redefinition of retirement or a redetermination of what constitutes poverty. Nor are they suddenly going to become affluent. It may surprise you to know that some people have the audacity to outlive their resources.

With that last thought I feel it time I concluded my remarks. I thank you for your time and attention.

Problems and Prospects of Providing and Receiving Health Services in Rural Montana

Home Health care in Montana is in its infancy. The majority of agencies have been in existence less than ten years. The development of new agencies in an the expansion of existing agencies into rural areas has been retarded by the reimbursement practices of Medicare and Medicaid, the failure to private insurance companies to include home health care as part of their benefits and the complexity of the home health care regulations on licensing, certification and fiscal management. The two most critical problems facing Home Health Agencies in Montana are inadequate reimbursement and the complexity of federal and state regulations governing Home Health Agencies.

Rural areas on Montana who are interested in developing a Home Health Agency are faced with the same requirements as large urban agencies for licensing, certification and reimbursement procedures. The sheer volume of these regulations often deter rural health care institutions or agencies from developing programs. The cost of delivery of care may be increased because of the distances it is necessary to travel between patients, the difficulty in attracting and retaining competent professional staff and development of community awareness of the program.

Home Health care has been identified as a viable alternative to more expensive forms of institutional health care. However, reimbursement is limited by Medicare and Medicaid to cover skilled care. This position fails to recognize the contribution of Home Health Services in preventing hospitalization of the chronically ill patient, the provision of supportive services to families who are able to maintain patients with heavy care demands or to the value one time visits to determine the response of some patients to early discharge from a Health Care Institution. There are minimal incentives for Home Health Care Agencies to deliver services to those clients without financial resources to pay full costs or are covered by 3rd party sources.

The Health Care Financing Agency continues to refine and redefine what it considers to be the intent of the Medicare law. The cost of developing and changing regulations is costly to the Federal regulatory system. However, it is even more costly to the agencies who deliever care. Agencies most continually review new regulations for impact on both the service delivery and billing systems. More and more of staff time is spent in documentation of care, development of protocol to respond to service delivery needs and in changing billing and bookkeeping systems.

This is related back to the government in the form of increased fees. It is also difficult to develop consistent national reimbursement policies as each intermediary has a tendency to interpret the meaning of the Medicare regulation, differently.

The Montana Association of Home Health Agencies is in opposition to the Medicare caps, lowering the Home Health reimbursement limits from the 80th to 75th percentile and to the removal of the expanded home health provision passed by last year's Congress. We are in support of the Medicaid Community Care Act.

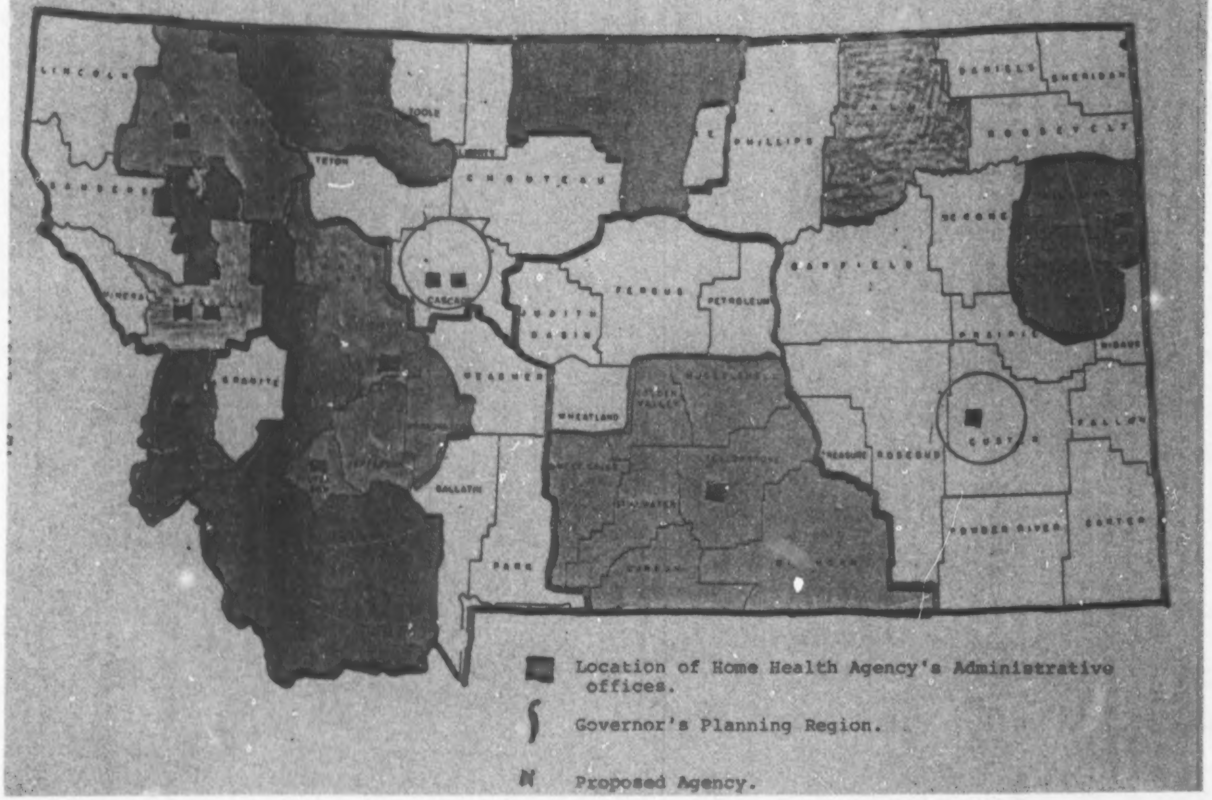
It is facinating that Congress is looking at ways to reduce reimbursement in an era when the use of Home Health Care is seen as a vilable and often less costly alternative to institutionalized care. It is a fact that a very small portion of the American Health Care dollar is spent on Home Health Care Services.

Respectfully submitted.

JANICE TREML,
President, Montana Association of Home Health Agencies.

MONTANA COUNTIES COVERED BY

HOME HEALTH SERVICE AGENCIES


LINCOLN
SANDERS
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LIBERTY
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CHOUTEAU
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JUDITH BASIN
FERGUS
PETROLEUM
MEAGHER
WHEATLAND
GALLATIN
PARK
PHILLIPS
DANIELS
SHERIDAN
ROOSEVELT
MCCONE
GARFIELD
PRAIRIE
WIBAUX
FALLON
CUSTER
TREASURE
ROSEBUD
POWDER RIVER
CARTER
GOLDEN VALLEY
STILLWATER

■ Location of Home Health Agency's Administrative offices.

∫ Governor's Planning Region.

N Proposed Agency.

BEST COPY AVAILABLE

JUDITH BASIN CITY-COUNTY PLANNING BOARD,
Stanford, Mont., June 29, 1981.

Senator MAX BAUCUS,
Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR SENATOR BAUCUS: We read with interest an article concerning a hearing in Billings regarding health care in smaller communities. For the past couple years our office has been involved in obtaining better health care for our entire county. Judith Basin County has been designated a manpower shortage area for the past several years and it seems our medical problems are getting worse as time goes on.

Enclosed you will find results of a countywide survey we did concerning medical care. We also sent along a few articles pertaining to our role in this problem. We have a large file of letters, meetings, and newspaper articles that prove our critical needs in this county for some kind of medical care that is closer than an hours drive away.

We hope you will examine this written testimony and inform us of the end results of your hearing and federal programs research.

Sincerely,

IRVIN LARSON, *Chairman.*

Enclosure.

ATTITUDES, PERCEPTIONS AND HEALTH CARE BEHAVIOR PATTERNS OF HOUSEHOLD MEDICAL DECISIONMAKERS IN JUDITH BASIN COUNTY, MONT.

(By S. L. Lahren, Jr., Ph. D., Applied Anthropologist Research Specialist)

INTRODUCTION

Within recent years, it has become increasingly apparent in the United States that rural health care delivery systems are rapidly becoming inadequate. Historically, because of population concentration (urbanization), the health needs of the urban segments of our society have taken precedence over their rural counterparts. As a consequence of this process, rural health delivery systems have not followed a carefully planned and integrated developmental sequence. This is primarily because of a lack of adequate out-patient facilities and adequate numbers of qualified medical personnel willing to serve in remote areas. There is no question that there continues to be a need for primary health care in rural areas, and that this need changes as these communities change in size and complexity.

In recent years, medical and non-medical researchers alike have acknowledged that socio-environmental factors are equally as important in disease causation as the traditional germ theory. Appropriate rural health care delivery systems should acknowledge the interconnected social, economic and health status characteristics of the communities to be served. In the case of rural communities we must recognize and understand: (1) sub-cultural differences, (2) their various styles of seeking health care, (3) modes of maintenance, and (4) their perceptions regarding health and illness prevention.

Edward W. Hassinger, Professor of Rural Sociology and Community Health and Medical Practice at the University of Missouri writes:

"The problem of access to health services involves more than convenient location of facilities. It represents a complex interplay among beliefs, social organization, and patterns of behavior of health consumers as they relate to a complex health care system. To understand rural health consumer behavior, we need to consider the characteristics of rural society, the health care system, and the patterned behavior of people in seeking health care" (1976:1[illegible]4)

The purposes of this survey was to establish valid baseline data on demographic characteristics and the health needs of Judith Basin County residents for the City-County Planning Board. Specifically, the survey was to gather on the basis of proper research survey techniques from a representative sample of the residents data on (1) biographical characteristics, (2) perceived health status, (3) prior medical care utilization patterns, (4) attitudes toward the acceptance and use of medical facilities and staff and (5) awareness and importance of existing health care facilities, individuals and services.

METHODOLOGY

Survey instrument

The survey instrument used in this study was designed by Dr. S. L. Lahren, Jr. He has had extensive experience in questionnaire development, measurement and research methodology (see attached vita). This particular instrument was first used in 1977. Since that time it has been refined and administered to approximately 1,500 residents in 8 different counties.

Sampling procedure

Sampling procedures required a master list of households for Judith Basin County. Once the master list was constructed, it was verified by a number of local knowledgeable residents. This master list was stratified on the basis of voter precinct. Each household head was assigned to their appropriate voter precinct. This was done to ensure that when the random sample was drawn, it would accurately represent the geographic distribution of the actual population. For the purposes of sampling, a 0.95 confidence interval was used with a maximum of 6 percent error on any proportion derived from the data. This required 158 interviews to be conducted in Judith Basin County. There were 158 completed interviews.

Interviewing procedure

Prior to the actual administration of the survey questionnaire, a training session was conducted to familiarize the interviewers with the survey instrument. A document entitled "Instructions to Interviewers" prepared by Dr. Lahren was reviewed during the training session and each question was discussed. The interviewers were then asked to administer the instrument on each other and 3 or 4 other people they knew (e.g., spouse, aunt, friend). After they completed their surveys, another session was held to discuss any problems encountered and review the entire instrument again.

Interviewers were assigned certain precincts and were responsible for obtaining the specific number of questionnaires from that precinct. Interview procedures varied depending on the interviewer. Some established appointments by telephone while others simply went door to door with no prior arrangements. Interviewing began with a standard explanation of the nature of the project, the type of questions that would be asked, and the importance of the informant's cooperation. The length of interviews varied considerably but generally took between 30 to 60 minutes to complete. Each interviewer carried a letter of introduction from the City-County Planning Board in the event an informant wished to verify the project before consenting to be interviewed. Each interviewer was required to identify and interview the medical decision maker of the randomly selected household. This was done by asking who was primarily responsible for making the decision to seek health care.

Data compilation

The second phase of the survey involved compiling the questionnaire data in a form that would render it useful for analytic purposes. Upon completion of the survey, the data were transferred to standard IBM 80 column code sheets. Specific coding instructions were prepared and each interviewer was responsible for translating to a transcriber his/her own questionnaire responses. Code sheets were then keypunched and a program designed to verify the data deck was run to check for errors in coding. Presently, the data is stored on keypunch cards.

The Statistical Package for the Social Sciences (SPSS) series was selected to program the data. Frequency distributions and measures of central tendency were used for analyzing the data.

DESCRIPTIVE DATA SUMMATION

Introduction

The purpose of this section is to provide a detailed summation of the descriptive data pertaining to the survey of Judith Basin County residents. These data include: (1) biographical characteristics, (2) perceived health status, (3) prior medical care utilization patterns, (4) attitudes toward the acceptance and use of medical facilities and staff and (5) awareness of health care facilities, individuals and services and ascribed importance. The data presented in each of these sections will be descriptive in nature.

Biographical characteristics [1]

Of those interviewed 82 percent were female and 79 percent were married. The average age of the respondent was 50 years and where applicable, the spouse's average age was also 50. Ninety-one percent had an average of 3 children and 2 are living at home. The respondents which are predominantly female averaged 13 years of education and their spouse had 12 years.

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[1] In the summary data any category with less than 10 percent will not be discussed.

Household composition consists mainly of married couples with children. Only 16 percent lived alone, 20 percent were husband and wife, and 61 percent were married with children. Three percent or four respondents have someone else in the household (e.g., aunt, grandmother).

Employment and income are the next two variables discussed. Of the respondents (which were 82 percent female) 38 percent were employed, 48 percent not employed and 14 percent retired. Seventy-nine percent of those employed were full time. Among their spouses, 69 percent were employed, 15 percent were not employed and 17 percent were retired. Ninety percent of those employed were full time employees. Considering their type of occupation, the respondents (mainly female) listed 26 different occupations of which the highest percentage listed was 28 percent in agriculture. The next highest were teachers and secretaries with 10 percent. Among the spouses 32 occupations were listed and 47 percent of those listed were in agriculture. When asked their major source of income, 39 percent were self-employed, 31 percent were employees, 16 percent were on social security and the other 14 percent were scattered among several sources. The next question asked was amount of net income they received per month. Sixteen percent refused to answer this question. However, of the 84 percent who did the average net income per month was $1,022.

Residence patterns are important when analyzing the biography of county residents. When asked which community they considered themselves a member they responded in the following manner:

	Percent
1. Hobson	15
2. Geyser	12
3. Denton	18
4. Coffee Creek	4
5. Stanford	31
6. Moccasin	4
7. Total	84
8. 10 other counties	16
9. Total	100

Their years of residence in the county had considerable time depth which indicates a stable population. Their years of residence were:

	Percent
1. 10 years or less	15
2. 11-20 years	13
3. 20+ years	72
4. Total	100

The final questions asked in the biographical section of the questionnaire were religious affiliation and attendance. Twenty-five percent listed Catholic, 18 percent were Methodists, 14 percent Presbyterian and 18 percent listed other Protestant religions. Forty-six percent attend church regularly, 23 percent occasionally and 19 percent rarely. Twelve percent never attend.

Perceived health status

The first important dimension of health care explored in the survey questionnaire was the respondents' perceived health status. The respondents were asked to rank their health status, their spouse's and their children's where applicable on a scale from 1 to 5 with 1 meaning poor and 5 representing excellent. The gave the following responses:

[In percent]

	Respondent	Spouse	Children
0. Undecided	0	0	0
1. Poor	4	2	1
2. Fair	8	10	2
3. Satisfactory	10	10	9
4. Good	47	48	37
5. Excellent	32	31	51
6. Total	101	101	100

From their responses 79 percent view themselves in good or excellent health and they view 79 percent of their spouses and 88 percent of their children in the same categories.

Another important characteristic of the respondents which appears to be a contradiction between perceptions and reality is the presence of chronic or long-term illnesses. While a majority perceive their health as good or excellent, 43 percent admit to having long term or chronic illnesses. Among this 43 percent or 68 respondents there were 14 distinct illnesses and 22 combinations for a total of 36 responses. Of the 68, 51 percent had high blood pressure/heart disease, 23 percent had arthritis and 12 percent had allergies.

Health care behavior patterns

Two critical factors that affect health care delivery system planning are present and past user patterns of the target population. Often, development organizations have constructed new clinics and hospitals or improved the quality of existing ones only to find that their efforts were unsuccessful primarily because such improvements did not guarantee behavioral changes in the consumer or user population. This section will illustrate the present user patterns of Judith Basin County.

The first variable considered is whether or not the user population has a family physician and why or why not. This variable should indicate the potential mobility of the population in terms of user patterns. Also, it will reveal something about their perceptions of the quality of medical care available in their communities and their degree of satisfaction with present care.

Judith Basin County residents definitely have a preference for a family doctor. Eithty-six percent of those interviewed have a family doctor. This preference for a family doctor is also reinforced by their response when asked: With whom do you first discuss your health problems?

Forty-seven percent contact their family doctor and 35 percent talk to their spouses.

When asked if they received regular medical care they responded:

[In percent]

	Respondent	Spouse	Children
1. Yes	73	55	74
2. No	27	45	26
3 Total	100	100	100

Of those who answerded yes, 85 percent of the respondents, 91 percent of the spouses and 65 percent of the children have regular yearly check-ups. Those who did not receive regular care felt it was not necessary. Generally, the population was divided between Great Falls and Lewistown in terms of the location where they were seen.

[In percent]

	Respondent	Spouse	Children
1. Lewistown	50	40	39
2. Great Falls	41	46	30
3. Basin Medical Center	0	0	16
4. Total	91	86	85

Note.—In all three of these groups 94 percent saw a physician.

During the last two years 40 percent of the respondents, 40 percent of the spouses and 61 percent of the children have seen a physician for an illness. Among those seeing a physician, colds and flu were the only illnesses cited that accounted for more than 10 percent. Respectively, 15 percent of the respondents, 22 percent of the spouses and 30 percent of the children had colds and/or flu. They were seen at the following locations:

[In percent]

	Respondent	Spouse	Children
1. Lewistown	56	48	47
2. Great Falls	33	28	32
3. Stanford	0	8	0
4. Total	89	84	79

Note.—In all three groups over [illegible] percent were seen by a physician.

Hospitalization among the respondents and their families occurred with less frequency. Twenty-seven percent of the respondents, 16 percent of the spouses and 21 percent of the children were hospitalized. These three groups were hospitalized for a variety of reasons but the most frequent reasons were OB and surgery. Location of hospitalization was as follows:

[In percent]

	Respondent	Spouse	Children
1. Lewistown	48	40	28
2. Great Falls	29	40	55
3. Total	77	80	83

Having completed recording their actual contact with medical facilities and staff for regular care, illnesses and hospitalization, two questions were asked to probe the respondents' perception of the availability of medical care. They were first asked if they needed medical care but chose not to get it. Twenty-three percent of the respondents stated they needed care but chose not to get it. Of the group 20 percent felt that it was a small illness and did not want to take up the doctor's time, 22 percent cited distance and road conditions and 14 percent felt they did not have time. The next question asked was if they received care and if it was difficult to get. Nineteen percent thought it was difficult and 81 percent felt there was no problem. Of the 19 percent citing problems 58 percent listed roads/distance and 13 percent had difficulty in getting appointments. On the other hand, of the 81 percent who had no problems 15 percent stated distance was not a problem and 76 percent of the 81 percent said care was readily available.

The last set of questions in the health use section dealt with emergency care. Forty-eight percent said 24 hour doctor coverage was available and 47 percent stated it was not. In an emergency 30 percent call their family doctor and 44 percent would call an ambulance. Only 8 percent experienced an emergency in the last year. Of this 8 percent or 12 people, 3 called the Hobson ambulance, 3 called Denton and 3 called the Stanford ambulance. Ninety-one percent were unaware of any improvements needed for the ambulance service. Eighty percent felt there was a need for a universal phone number.

Another important variable that influences user patterns and medical decision making is the presence or absence of health insurance. Health insurance often plays a major role in decisions regarding whether or not to seek medical attention (except in very serious circumstances). Those with insurance tend to utilize health care services more readily than those without.

Eighty-eight percent indicated they have health insurance. Of the insured portion of the sample, 30 percent are covered by employee insurance and 64 percent have purchased coverage for themselves. This latter group purchases from 53 different companies with Blue Cross and Blue Shield being the most popular. Only a small percentage received Medicaid (1 percent) and Medicare (7 percent) benefits.

Attitudes toward medical facilities/staff

The next set of questions was designed primarily to track those respondents, spouses and children who did not have any regular care, illnesses or hospitalization during the last two years. These questions allow a summary of where all the respondents, spouses and children personally go for health care. They also measure the respondents' attitudes toward these facilities and staff and their feelings regarding the types of improvements they see as necessary. These questions were explored for both the clinic and hospital.

When asked to state the name of their physician, the respondents listed 51 different physicians for themselves, 39 for their spouses and 35 for their children. These physicians were considered family doctors by 79 percent of the respondents and spouses and 74 percent of the children. The reasons they gave for seeing these physicians ranged from 20 different reasons among the children to 30 among the spouses. The most frequently cited reason for seeing a particular doctor was because they were recommended by someone. Physician competence and availability were the next two most important reasons. Eighty-seven to 95 percent of the people surveyed use their car for transportation. As discussed above, most of the respondents did not seem to feel that distance was a factor in receiving medical care. However, when specifically asked if distance was a problem among these three groups, only 62 percent of the respondents felt that distance to these facilities was satisfactory.

In terms of where they would go for hospitalization 48 percent said Lewistown and 45 percent listed Great Falls. Eighty-five percent rated the facility good or excellent and 77 rated the quality of care as good or excellent.

Sixty percent of the respondents listed the Basin Medical Center as the clinic closest to them. Only 46 percent of the respondents listed the care in the clinic closest to them as good or excellent. Thirty-four percent were undecided. Fifty percent of the respondents cited availability of the doctor as the major problem.

Currently, there is a considerable discussion among health care providers as to the use of nurse practitioners as a means to augment helath care delivery in rural areas. In order to assess the receptivity of this population to the use of such an alternative, the respondents were asked if they were aware of nurse practitioners and if they would use them. Generally, they were unaware of them and misinformed about their capabilities. However, after describing their activities, 75 percent thought they would use them. Of this 75 percent, 8 percent would use them if no doctor was available, 11 percent for common illnesses and 42 percent if they were available. It was a feeling of "they are better than nothing."

Medical facilities, services, staff/awareness-importance

One of the most important dimensions affecting the provision of quality medical care to a population is the degree to which that population is aware of the various facilities, services and professional staff available to them. The variables in this section were designed to explore their degree of awareness and how important they feel each is in the community (see table, page 13).

Generally, the respondents were aware of either the presence or absence of those items listed. The "don't know" column ranged from 1 percent to 27 percent. In most cases their awareness was minimal.

Interestingly, however, was the importance they ascribed to the various items listed. The most important medical personnel were EMTs with 89 percent listing them as very important and ambulance services with 97 percent listing it as very important. The next items listed with the highest percentage in the very important category were blood pressure, immunizations and pharmacy with 74 percent, 73 percent and 73 percent respectively. As for the other items listed, 55 percent or less felt they were very important.

This general lack of ascribed importance is probably due to the fact that most of these services, facilities and personnel have not been present in Judith Basin County and therefore the residents do not perceive them very important based on their past experience. However, it is obvious in the case of EMTs, ambulance services and pharmacy that they have been present and are perceived as very important.

Stanford clinic?

The final set of questions to be described in this study are those pertaining to prior use of the clinic in Stanford and prospective questions asking the respondents if they would use a clinic in Stanford. Fifty-three percent used the clinic and 47 percent did not. Seventy percent of those who used it cited convenience as the major factor in their decision. Of the 47 percent who did not use it, the following reasons were cited for non-use:

	Percent
1. Unaware	27
2. Established elsewhere	23
3. Lived elsewhere	23
4. Not needed	24
5. Total	97

Individual/facility	Present	Awareness percent		Importance percent				
		Absent	Don't know	Very important	Somewhat important	Somewhat not important	Not important	No opinion
Physicians	45	49	6	55	25	7	13	...
Public health nurse	22	57	21	36	27	10	23	5
School nurse	74	18	8	55	21	6	14	4
EMT	73	13	13	89	4	1	5	1
Dentist	48	46	6	36	25	9	27	3
Optometrist	46	49	5	32	24	11	31	1
Mental health center	13	77	10	17	22	16	42	3
Chiropractor	13	84	1	23	17	9	47	3
Clinic	37	59	3	47	21	8	21	3
Laboratory	17	75	8	30	22	11	35	3
Hospital	14	85	1	25	11	10	53	2
Emergency room	19	76	4	41	22	5	30	2
Ambulance service	98	1	1	97	3	...	...	...
Nursing home	13	84	3	29	23	11	34	3
Pharmacy	63	36	1	73	10	3	13	1
Are these screening clinics held in this area:								
Blood pressure	80	11	10	74	17	3	5	2
Immunizations	58	29	13	73	13	5	5	1
Diabetes/hypoglycemia	19	54	27	58	21	6	12	3

If a clinic was available 73 percent would use it and 28 percent would not. Of this 73 percent, 70 percent would use it because of the distance to other facilities and 11 percent would use it if the doctor was satisfactory. Of the 28 percent who would not use it, 45 percent were established elsewhere and 26 percent cited that it was closer to other facilities.

CONCLUSIONS

The remainder of this report is devoted to the analysis of the characteristics of the survey population and is presented as conclusions.

1. The population of Judith Basin County is the product of a rural socialization process. Hassinger's summation of research on rural characteristics (1976) corresponds quite closely to the results of this survey. Those characteristics are (1) the population age distribution is elderly in nature, (2) they are spatially and temporally isolated, (3) values common to rural populations include traditionalism, religious, residentially stable, work oriented, ethnocentric, fatalistic and family centered (our population appears to conform to these values as far as available questionnaire data can be generalized) and (4) interaction and information exchange tends to be face to face and through informal channels.
2. It appears that the female of the household is primarily responsible for medical decision making. She apparently decides user patterns, criteria for seeking medical attention and levels of satisfaction or dissatisfaction with present medical care and facilities. Any changes in the medical services in Judith Basin County must by necessity focus on the female to attain any degree of success.
3. A majority of the respondents viewed their health status and that of their families as good or excellent.
4. The respondents have a definite preference for a family doctor.
5. A majority receive regular medical care by having regular yearly checkups.
6. The population is about evenly divided between Great Falls and Lewistown for their medical care of all types (i.e., regular, illness and hospitalization).
7. They do seek health care when they need it and do not view distance as a problem. This is because they have never had an alternative.
8. Eighty percent felt there was a need for a universal phone number.

9. Eighty-eight percent of the respondents have medical insurance.
10. Their attitudes toward the medical facilities in Great Falls and Lewistown is positive.
11. The most important reason cited for seeing a particular physician was based on a recommendation by someone else. Physician competence and availability were the next two important reasons.
12. There were no dominant patterns in terms of the physicians seen by the respondents.
13. The user population is generally aware of the range of health care facilities, personnel and services offered in the county and they do not ascribe a high level of importance to all of the listed items.
14. Seventy-three percent stated they would use a clinic in Stanford.

RESULTS OF MEDICAL SURVEY HIGHLIGHTED

The purpose of this survey was to establish valid baseline data on demographic characteristics and the health needs of Judith Basin County residents for the City-County Planning Board. Specifically, the survey was to gather on the basis of proper research survey techniques from a representaive sample of the residents data on (1) biographical characteristics, (2) perceived health status, (3) prior medical care utilization patterns, (4) attitudes toward the acceptance and use of medical facilities and staff and (5) awareness and importance of existing health care facilities, individuals and services.

The research was conducted by Dr. S. L. Laharen, Jr. with the assistance of four local interviewers. A random sample of 158 households was drawn from the county and the medical decision maker of that household was interviewed. The following article highlights the results of the survey (a complete report has been submitted to the Planning Board).

The population of the county is definitely rural and 72 percent have lived in the county 20 years or more. The data on the survey reveal that agriculture is the economic base of the respondents with the supportive industries primarily a function of agricultural activity. The average age of the respondents is 50 years. Eighty-two percent of those interviwed were female. Therefore, it appears that the female of the household is primarily responsible for medical decision making. She apparently decides user patterns, criteria for seeking medical attention and levels of satisfaction or dissatisfaction with present medical care and facilities. Any changes in the medical services in Judith Basin County must by necessity focus on the female to attain any degree of success. A majority of the respondents viewed their health status and that of their families as good or excellent. The respondents have a definite preference for a family doctor. A majority receive regular medical care by having regular yearly check-ups. The population is about evenly divided between Great Falls and Lewistown for their medical care of all types (i.e., regular, illness and hospitalization). They do seek health care when they need it and do not view distance as a problem. This is because they have never had an alternative. Eighty percent felt there was a need for a universal phone number. Eighty-eight percent of the respondents have medical insurance. Their attitudes toward the medical facilities in Great Falls and Lewistown is positive. The most important reason cited for seeing a particular physician was based on a recommendation by someone else. Physician competence and availability were the next two important reasons. There were no dominant patterns in terms of the physicians seen by the respondents. The user population is generally aware of the range of health care facilities, personnel and services offered in the county and they do not ascribe a high level of importance to all of the listed items. Seventy-three percent stated they would use a clinic in Stanford.

We would like to take this opportunity to thank all those who participated in the survey.

PROJECT '80 MEETING, JUDITH BASIN COUNTY COMMUNITY DEVELOPMENT COMMITTEE

A. COUNTY MEDICAL FACILITY WITH FULL TIME DOCTOR, DENTIST, OPTOMETRIST, ETC.

Recommendation: We recommend that a county wide medical study be done first. This would indicate whether or not the people in the county would support such a facility if one were built. We suggest that those persons who are able, make voluntary contributions that would be matched by federal funds in order to build this facility. A doctor or dentist who would prefer living in a rural area would be strongly recommended.

B. NEW ROAD BETWEEN HOBSON AND GEYSER

Recommendation: We recommend to continue to press for progress on the Geyser-Stanford section and as soon as that section is completed press for the next section from Stanford to Hobson. We feel this can be accomplished if the communities pull together—write letters, attend meetings, etc. Farm to market roads should also be included in this project.

C. COUNTYWIDE SOLID WASTE AND ZONING PROGRAM

Recommendation: We recommend that the Judith Basin City-County Planning Board be assigned to look into these projects and have these programs initiated into their 1980 agenda. We suggest public hearings and public input be used as a basis for completing this project.

D. IMPROVED RAILROAD LINES AND PUBLIC TRANSPORTATION

Recommendation: We recommend that the Public Service Commission be contacted and be made aware of the problems and needs of the residents of Judith Basin County.

E. SMALL INDUSTRY INTO COUNTY

Recommendation: We recommend a county-wide effort by all concerned citizens of Judith Basin County to solicit and urge small businesses to locate in our area. Those of particular urgency are: welding shop, machine shop, general repair shop, electronics, fresh meat market, custom slaughter and wrapping.

F. ENERGY DEVELOPMENT IMPACT STUDY (COAL, NATURAL GAS, GASAHOL, OIL, ETC.)

Recommendation: We recommend that the Judith Basin City-County Planning Board be responsible for finding the proper media and personnel to adequately handle this project.

G. REORGANIZE TAX BASE

Recommendation: We recommend that the legislators appoint an interim committee to study and evaluate the present tax structure, as we feel the present system is unfair and inadequate.

H. LIMIT GOVERNMENTAL AND ORGANIZATIONAL INTERFERENCE CONCERNING ENVIRONMENTAL USES

Recommendation: We recommend that the general public be more active and verbal concerning environmental policies in regard to oil, gas and coal development, power, power lines, power plants, predator control and all other areas where environmental problems exist.

I. IMPROVE SCHOOL FACILITIES COUNTYWIDE

Recommendation: We recommend that the communities themselves keep track of any impact that may incur on their particular school system and steps be made to cope with the impending situation.

JUDITH BASIN CITY-COUNTY PLANNING BOARD,
Stanford, Mont., February 10, 1981.

REGION 3-A EMERGENCY MEDICAL SERVICE COUNCIL,
621-A 2nd Street South,
Glasglow, Mont.

DEAR SIRS: The members of the Judith Basin City-County Planning Board would like to stress the need for improved emergency medical services in this area.

The community of Stanford had an increase of 90 persons in the last census going from 505 in 1970 to 595 in 1980, an increase of 17.8 percent. Several other communities in our county also saw substantial growth. We know our county is going to continue to grow and, thus, make even greater demands on our emergency services.

One of the reasons we feel our county will increase in population and want of more medical services is because of the very real possibility of coal development in our area. The members of the planning board have attended numerous meetings, seminars, and workshops concerning coal impact by the request of the Western Energy Company.

The Planning Board would also like to mention that the highway in which the ambulance has to travel is in horrible condition. The traffic is heavy and the road is very old, narrow and dangerous.

With just these three factors in mind we would hope you can see great need for improved medical services in our area.

Sincerely,

IRVIN LARSON, *Chairman.*